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THE
INSURANCE
LAW JOURNAL.

REPORTS OF ALL DECISIONS
RENDERED IN INSURANCE CASES IN THE FEDERAL COURTS
AND IN THE STATE SUPREME COURTS.

WALTER S. NICHOLS,
WILLIAM OTIS BADGER JR., } Editors.

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THE
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REPORTS OF ALL DECISIONS

RENDERED IN INSURANCE CASES IN THE FEDERAL COURTS, AND IN THE STATE SUPREME COURTS.

From certified transcripts in our possession.

LIFE.

SUPREME COURT OF INDIANA.

METROPOLITAN LIFE INS. CO.

vs.

SOLOMITO. (No. 22936.)*

1. INSURANCE—LIFE INSURANCE—VIOLATION OF POLICY.

False representations in application for a life insurance policy relative to the health of the insured at and previous to issuance, his being attended by a physician, etc., render the policy voidable at the election of the insurer.

(For other cases, see Insurance, Cent. Dig. §§ 691, 692; Dec. Dig. § 292.)

2. INSURANCE—LIFE INSURANCE—PROVISIONS RELATIVE TO HEALTH—VIOLATION—DEFENSE.

An answer setting up the fact in election to rescind and avoid the contract for breach of stipulations as to the insured's health prior to and at time of application, and showing a reasonable offer to return the premiums received, when established by proof, constitutes good defense to an action on the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1617, 1618; Dec. Dig. § 640[2].)

Appeal from Circuit Court, Owen County; James B. Wilson, Judge. Suit by Vito Solomito against the Metropolitan Life Insurance Company. From a judgment for plaintiff, defendant appeals. On transfer from the Appellate Court under Burns's Ann. St. 1914, § 1405 (Acts 1901, c. 259). Judgment reversed, with instructions to the trial court to

* Decision rendered May 16, 1916. 112 N. E. Rep. 521.

restate its conclusions of law and render judgment in conformity with the opinion.

Stotsenburg & Weathers, of New Albany, for Appellant.
Thomas G. Spangler and Herbert A. Rundell, both of Spencer, and
Wm. M. Louden, of Bloomington, for Appellee.

Cox, J.

Appellee sued to recover on a policy of industrial life insurance issued by appellant on the life of one Myk Kovacevie, in which appellee was the named beneficiary. Appellee is an Italian, and Kovacevie was an Austrian. They were not related. The amount of the policy was \$275, one-half only of which sum was to be paid if death occurred within six months. The application for the insurance was made May 8, 1912, and the policy was issued on May 20, 1912. Kovacevie died August 27, 1912, of valvular heart disease and dropsy.¹ In the written application for the policy it was stated that no physician had attended the insured for any complaint within two years prior to the date of the application, and that he had never been under treatment in any dispensary or hospital. The policy provided:—

"That no obligation is assumed by the company prior to the date hereof, nor unless on said date the insured is alive and in sound health."

It was further provided that:—

The "policy is void if the insured before its date * * * has been attended by a physician for any serious disease or complaint, or has had before said date any * * * disease of the heart," etc.

Appellant answered the complaint by general denial and five special answers, in which the absence of insurable interest and the violations of the conditions set out above were presented as defenses. The issues formed by general denials of the special paragraphs of answer were tried by the court. On request the facts were specially found, and on them the court stated conclusions of law favorable to appellee and rendered judgment accordingly. Appellant's exceptions to the conclusions of law present the only questions involved in the appeal.

The court found, among other things, that in the written application of Kovacevie to procure the insurance it was stated by him that no physician had attended him for any complaint within two years prior to the date of the application, and that the statement was made by the insured for the purpose of inducing appellant to issue the policy of insurance sued on; that among other considerations in the policy it was provided that no obligation was assumed by the insurer by the policy unless on the date of the policy the insured was in sound health; that at the time of the application for the insurance, and at the time of the date of the policy, the insured was not in sound health, but was then and there suffering from a disease and ailment known

as hernia, which fact was then and there well known to insured, but was wholly unknown to insurer; that prior to the application for the policy and to its date, in April, 1912, the insured was attended by a regular practicing physician for a serious disease and complaint, namely, hernia; that after receiving proofs of death insurer discovered for the first time the facts set out above, and immediately thereafter it notified appellee of its election to avoid the policy, and it thereupon tendered back the premiums received, and upon appellee's refusal to receive them paid them into court.

[1,2] No question of waiver or estoppel was raised by the pleadings, and the court erred in its conclusions of law in favor of appellee. Provisions in a life insurance policy like those here involved are held to render the policy voidable at the election of the insurer, and answers setting up the facts in election to rescind and avoid the contract and showing a reasonable offer to return the premiums received when established by proof constitute a good defense to an action on the policy. Commercial Life Ins. Co. vs. Schroyer (1911) 176 Ind. 654, 95 N. E. 1004, Ann. Cas. 1914A, 968; Metropolitan Life Ins. Co. vs. Johnson (1911) 49 Ind. App. 233, 241, 94 N. E. 785; Metropolitan Life Ins. Co. vs. Wolford (1911) 49 Ind. App. 392, 97 N. E. 444; Metropolitan Life Ins. Co. vs. Willis (1906) 37 Ind. App. 48, 76 N. E. 560; Catholic Order of Foresters vs. Collins (1912) 51 Ind. App. 285, 99 N. E. 745.

Appellant's answers fully met the requirements of the law in pleading the falsity of material representations on the part of the insured and the election of the insurer to avoid the policy, and the court found the facts in support of such answers. For this reason, the conclusions of law should have been for appellant.

The conclusion reached makes it unnecessary to consider the claim of appellant that the insurance was taken by appellee on a life in which he had no insurable interest and was therefore void.

Judgment reversed, with instructions to the trial court to restate its conclusions of law and render judgment in conformity with this opinion.

SUPREME JUDICIAL COURT OF MASSACHUSETTS.

ESSEX.

FONDI

vs.

BOSTON MUT. LIFE INS. CO.*

1. INSURANCE—LIFE INSURANCE—COMPLIANCE WITH CONDITION OF POLICY—BURDEN OF PROOF.

In an action on two policies of life insurance, providing that no obligation was assumed by the insurer prior to the dates of the policies, unless insured was alive, in sound health, etc., plaintiff had the burden of showing, as to each policy, by fair preponderance of the evidence, that insured was in sound health on date of policy.

(For other cases, see Insurance, Cent. Dig. §§ 1555, 1645-1649; Dec. Dig. § 646[1].)

2. INSURANCE—LIFE INSURANCE—PROOF OF PERFORMANCE OF CONDITION PRECEDENT—STATUTE.

Proof of performance of a condition precedent to the taking effect of a life insurance policy is not affected by St. 1907, c. 576, § 21, providing that no warranty made by insured in the negotiations for a policy of insurance shall be deemed material, or defeat or avoid the policy, unless made with actual intent to deceive, or unless the matter made a warranty increased the risk of loss.

(For other cases, see Insurance, Cent. Dig. §§ 1555, 1645-1649; Dec. Dig. § 646[1].)

Exceptions from Superior Court, Essex County; Jabez Fox, Judge.

Action by Guisseppe Fondi against the Boston Mutual Life Insurance Company. Verdict for plaintiff, and defendant brings exceptions. Exceptions sustained.

Jas. J. Sullivan and Michael A. Sullivan, both of Lawrence, for Plaintiff.

John P. S. Mahoney and Cornelius J. Mahoney, both of Lawrence, for Defendant.

RUGG, C. F.

[1, 2] This is an action of contract whereby the plaintiff seeks to recover on two policies of insurance on the life of Edwardo Contestabile. Each policy contained this among other conditions:—

"Provided, however, that no obligation is assumed by said company prior to the date hereof nor unless on said date the insured is alive, in sound health. * * *"

There was evidence tending to show that on the date of each policy the insured was not in sound health, but was suffering from tuberculosis. In this state of the evidence the jury were instructed that:—

"The burden of proof in this case to show that this policy

*Decision rendered, May 16, 1916. 112 N. E. Rep. 612.

has been avoided by breach of the condition referred to, rests upon the defendant. That is, unless he satisfies you by a fair preponderance of the evidence that the conditions of the policy are broken, then you should bring in your verdict for the plaintiff."

Exemption was duly saved to this instruction. The instruction was erroneous. The correct principle of law was called to the court's attention by the defendant's requests for ruling, to the effect that, in order to recover, it was necessary for the plaintiff to show as to each policy by a fair preponderance of the evidence that on its date the insured was in sound health. When it is made a condition precedent to the taking effect of a policy of insurance as a binding contract, that the insured shall be in sound health on its date, then the burden of proving compliance with that condition rests on the plaintiff. *Barker vs. Metropolitan Life Insurance Co.*, 188 Mass. 542, 547, 74 N. E. 945; *Lee vs. Prudential Life Ins. Co.*, 203 Mass. 299, 301, 89 N. E. 529, 17 Ann. Cas. 236; *Everson vs. General Accident Fire & Life Assur. Corp.*, 202 Mass. 169, 172, 173, 88 N. E. 658. Proof of performance of a condition precedent of the policy is not affected by St. 1907, c. 576, § 21, to the effect that:—

"No * * * warranty made in the negotiation of a * * * policy of insurance by the assured * * * shall be deemed material or defeat or avoid the policy * * * unless * * * made with actual intent to deceive or unless the matter * * * made a warranty increased the risk of loss."

The distinction between a warranty and a condition precedent in connection with a contract is plain.

[3] The error of the misdirection touching the burden of proof was not cured by the further instruction that if it appeared to the minds of the jury "that the man was not in sound health at the time when the policy was taken out, then by the express terms of the policy there could be no recovery." This sentence contains no reference to the burden of proof.

Requests 12 and 13, to the effect that if the insured had some disease of the lungs on the date of either policy, there could be no recovery, were given in substance.

[4] A physician who had examined the insured during December, 1908, when the policy of earlier date was issued, testified to sending some sputum, given him by the insured, to the state board of health. The defendant, through one of its employees, then offered in evidence a copy of a card from the office of that board, together with evidence that he had seen the original which had been destroyed. The card with its inferences appeared to show that the sputum sent by the examining physician had been tested by the "bacteriologist" and found to be tuberculous. It appeared that examinations and records of this sort were made and kept by the state board as a part of

its voluntary activities without legislative requirement. It was not a public record in the sense of R. L. c. 35, § 5. It did not appear that the bacteriologist who made the test might not have been called as a witness. *Cashin vs. N. Y., N. H. & H. R. R.*, 185 Mass. 543, 546, 70 N. E. 930. It did not relate to matters as to which records were required to be kept. *Butchers' Slaughtering & Melting Ass'n vs. Boston*, 214 Mass. 254, 259, 101 N. E. 426. This copy was excluded rightly. *Allen vs. Kidd*, 197 Mass. 256, 259, 84 N. E. 122; *P. Garvan, Inc., vs. N. Y. C. & H. R. R. R.*, 210 Mass. 275, 279, 96 N. E. 717; *Com. vs. Borasky*, 214 Mass. 313, 317, 101 N. E. 377; *Jewett vs. Boston Elevated Ry.*, 219 Mass. 528, 532, 107 N. E. 433; *Nichols vs. Commercial Travelers' Ass'n*, 221 Mass. 540, 547, 109 N. E. 449.

[5] The plaintiff was entitled to interest on the verdict. The jury returned a verdict for a sum "with interest." While they were in their seats and before the verdict was recorded, it was amended by direction of the judge by the addition of interest, which then was affirmed by the jury and recorded. In this there was no error. *Minot vs. Boston*, 201 Mass. 10, 86 N. E. 783, 25 L. R. A. (N. S.) 311; *Whitney vs. Com.*, 190 Mass. 531, 540, 77 N. E. 516; *Randall vs. Peerless Motor Car Co.*, 212 Mass. 352, 387, 388, 99 N. E. 221.

Exceptions sustained.



SUPREME JUDICIAL COURT OF MASSACHUSETTS.

SUFFOLK.

SHEA

vs.

MANHATTAN LIFE INS. CO.*

1. INSURANCE—AGENCY FOR INSURER—RELATIONSHIP.

Where the general agent of an insurer instructed his soliciting agent, who was in his direct employ, to deliver a check in payment of a policy to the beneficiary, in so doing the soliciting agent was the agent of the insurer.

(For other cases, see *Insurance*, Cent. Dig. §§ 99, 100; Dec. Dig. § 73.)

2. INSURANCE—AGENTS—SCOPE OF EMPLOYMENT—PAYMENT OF POLICY.

Where a soliciting agent on instruction of the general agent took a check in payment of a policy to the beneficiary, he might be found to have been acting within the apparent scope of his authority in securing the beneficiary's indorsement on the back and returning the check to the

* Decision rendered, May 17, 1916. 112 N. E. Rep. 631.

general agent, where the beneficiary refused to accept the check and insisted upon having cash.

(For other cases, see Insurance, Cent. Dig. § 103; Dec. Dig. § 78.)

3. INSURANCE—PAYMENT OF POLICY—CHECK.

If a check in the amount of a policy is actually delivered to the beneficiary, that may operate as payment of the policy, but, where the agent merely secured the beneficiary's indorsement on a check, and on her refusal to accept the check and insistence upon cash, delivery could not be inferred, even though she knew what the check and her indorsement were.

(For other cases, see Insurance, Cent. Dig. §§ 1495, 1496; Dec. Dig. § 599.)

4. INSURANCE—PAYMENT OF POLICY—MISAPPROPRIATION BY AGENT—LIABILITY OF INSURER.

If a beneficiary declines to accept a check, desiring cash instead, but indorses the check solely to secure the cash, and the agent thereafter misappropriates the cash, the insurer is liable; there having been no payment of the amount due under the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1495, 1496; Dec. Dig. § 599.)

5. INSURANCE—ACTIONS—FINDINGS OF JURY—INCONSISTENCY.

A general verdict for the plaintiff beneficiary, who sued to recover the amount of the policy, is not inconsistent with a finding that she indorsed a check offered in payment of the policy knowing what it was, when, in fact, the money was never received by her.

(For other cases, see Insurance, Cent. Dig. §§ 1785-1787; Dec. Dig. § 670.)

7. INSURANCE—ACTIONS—CONDITIONS PRECEDENT—RETURN OF THINGS RECEIVED.

Where the beneficiary of an insurance policy declined to accept a check, but demanded cash, and the agent took her indorsement, and later, instead of paying her the cash, persuaded her to leave it with him, as he claimed, for investment, and, as she claimed, on deposit, and he, in accordance with his claim, issued stock certificates for the amount so retained, it was not necessary for the beneficiary, who sued the insurer on the policy, to offer to return the certificates.

(For other cases, see Insurance, Cent. Dig. § 1520; Dec. Dig. § 612[1].)

Exceptions from Superior Court, Suffolk County; William B. Stevens, Judge.

Action by Bridget E. Shea against the Manhattan Life Insurance Company. Verdict for plaintiff, and to the court's refusal to set aside the verdict and give judgment for defendant, and to other rulings in the trial, defendant excepts. Exceptions overruled.

Francis M. Phelan and Jos. A. Conway, both of Boston, for Plaintiff. Robert Homans, of Boston, and Peter E. Costello, of South Boston, for Defendant.

CROSBY, J.

This is an action of contract, to recover a balance due upon two policies of life insurance for \$1,000 each, issued by the defendant to one Phipps, the plaintiff's former husband, in which the plaintiff is named as beneficiary.

The home offices of the defendant company were in the city

of New York; and there was a branch office in Boston in charge of one Mosher, who, the evidence showed, was the defendant's agent, cashier and manager, with duties fixed by the terms of his written contract of employment.

After proof of the death of the insured had been furnished to the defendant, the latter sent a check for \$2,000 to Mosher, payable to the order of the plaintiff. There was evidence that the check was given by Mosher to one Fletcher, an insurance broker (who obtained the policies in question for the insured), with instructions to take it to the plaintiff; that the plaintiff could neither read nor write; that she indorsed the check by her mark; and that it was returned by Fletcher to Mosher, who deposited it in his personal account. The plaintiff denied that she had ever seen the check or that she indorsed it.

Fletcher testified that she said she did not want a check but that she wanted the cash, that she indorsed the check and that he told her "to come up in a few days and get the money. * * *"

On February 23, 1910, the plaintiff went to the Boston office of the defendant, accompanied by Ellen Conroy, and received \$200 in cash from Mosher and gave a receipt in the following form:—

"Boston, February 23, 1910.

"Received from H. G. Mosher, manager, \$200, leaving a balance due on call of \$1,800.

her

"Bridget X Phipps. Ellen Conroy. \$200."
mark

The plaintiff testified that on her visit to the defendant's office, when she received the payment of \$200, Mosher asked her why she did not leave the money with them, the company would pay her 6 per cent interest and that she could get only 4 per cent from the savings bank; that he told her "it will be just as safe as the bank, and we will send you your interest every three months and you can come to this office at any time and get the whole or any part of your money;" that she said, "I will need \$200 of the money to pay the funeral expenses and I will leave the rest with the company."

She further testified that Mosher presented to her a paper to which she "touched a pen with which Mosher made a mark," and that at his request Mrs. Conroy witnessed her signature; that Mosher then handed her \$200 in cash and a large sealed envelope; that upon returning home she deposited the sealed envelope in a trunk; and that she had no knowledge of its contents until October, 1913, after there had been a failure in the payment of interest, when she opened the envelope and found contained a certificate of stock in a corporation known as Investors' Corporation Company.

At the close of the evidence, the defendant requested the court

to direct the jury "that on all the evidence, the jury must find for the defendant, and further, to rule that as the plaintiff did not offer to transfer to the defendant, before bringing suit, the twenty shares of Investors' Corporation Company stock she had in her possession at the time suit was commenced, she could not recover." The presiding judge refused so to rule, and submitted the case to the jury, who found for the plaintiff in the sum of \$1,800 with interest from the date of the writ. The jury, in response to special questions submitted to them, also found as follows:—

That the plaintiff indorsed with her mark defendant's check for \$2,000 knowing what it was.

That the defendant's check of \$2,000 was not given to the plaintiff in payment of the insurance on her husband's life.

That the plaintiff did not know she was receiving stock of the Investors' Corporation Company in lieu of the balance of \$1,800 cash due under her policy.

[1, 2] It is plain that Fletcher was the defendant's agent to deliver the check to the plaintiff, and he might have been found to have been acting within the apparent scope of his authority in procuring the plaintiff's indorsement upon the check, which he afterwards returned to Mosher, the defendant's manager; this was a fact involved in the finding of the jury. *Barry vs. Mut. Life Ins. Co. of N. Y.*, 211 Mass. 306, 97 N. E. 779; *Markey vs. Mut. Benefit Life Ins. Co.*, 103 Mass. 78.

[3] If the check had been delivered by Fletcher to the plaintiff, doubtless it would have operated as a payment of the amount due, but the jury could have found upon the evidence that it never was delivered to the plaintiff. The only evidence upon that subject is found in the testimony of Fletcher, who said that he did not know that she ever had it in her hand or possession, and in response to the question "Did you tell her the check was in payment of the policy?" replied, "Why I don't know what talk I made to her at that time." This and the other evidence warranted a finding that the check never was delivered to her, nor is such delivery to be inferred from the finding that she indorsed it knowing what it was. Such indorsement and knowledge alone did not prove a delivery to her and so cannot be regarded as conclusive evidence of payment.

[4] If the plaintiff declined to accept the check because she desired that the amount due her should be paid in cash, as the jury could have found, and she indorsed it solely for that purpose, it never having been delivered to her the defendant is liable, even if the proceeds were afterwards misappropriated by Mosher. It is liable in the same way that it would be had it sent cash to Mosher to pay the claim, and the plaintiff had declined to accept the cash so sent, because of the denomination of the bills, and Mosher had promised the plaintiff to have the bills changed and to pay her later, but failed to do so.

[5] The defendant originally owed the plaintiff \$2,000. The jury in effect have found that the balance of \$1,800 never has been paid either by check or otherwise.

The defendant claimed that the plaintiff invested the balance of \$1,800 in the shares of stock and received such stock in lieu of the balance due under the policies, but the jury have found against this contention. U. S. Wringer Co. vs. Cooney, 214 Ill. 520, 73 N. E. 803.

The general verdict for the plaintiff is not inconsistent with the finding made in answer to the first special question submitted to the jury.

[6, 7] The contention that the plaintiff cannot maintain this action because she did not offer to transfer and deliver to the defendant the certificates of stock in the Investors' Corporation Company cannot be sustained. It is familiar doctrine that one rescinding a contract for breach of warranty or fraud and who sues to recover back the consideration, must first put the defendant in *statu quo* by returning what he has received. Owen vs. Button, 210 Mass. 219, 96 N. E. 333; O'Shea vs. Vaughn, 201 Mass. 412, 87 N. E. 616; Miller vs. Roberts, 169 Mass. 134, 146, 47 N. E. 585; Bartlett vs. Drake, 100 Mass. 174, 97 Am. Dec. 92, 1 Am. Rep. 101.

This principle has no application to the facts in the case at bar. It is to be observed that this is an action of contract to recover the amount due upon the policies. The plaintiff does not seek to rescind a contract for the purchase of shares of stock, on the other hand she contends that she never entered into any such contract. In these circumstances she was under no obligation to offer to transfer the stock as a condition precedent to her right to begin the action. Besides, there is nothing to show that the defendant ever owned the stock in question or that it ever had any interest therein. We do not mean to intimate that the plaintiff is not bound to account for the stock to whoever may be entitled thereto. Her right to bring this action stands upon entirely independent grounds.

[8] It follows that the action of the judge in directing the jury to deduct from the amount due on the policies the value of the stock, if it had any, was error; but as that instruction did not injuriously affect the substantial rights of the defendant, it becomes immaterial. The amount of the verdict shows that no deduction was made on account of the stock.

As the rulings requested by the defendant could not properly have been given, the exceptions saved in each bill of exceptions must be overruled.

So ordered.

SPRINGFIELD COURT OF APPEALS.

MISSOURI.

KEMPF ET AL.

vs.

EQUITABLE LIFE ASSUR. SOC. OF UNITED STATES. (No. 1645.)*

1. INSURANCE—CONTRACT PENDING ACTION ON APPLICATION—DEATH BEFORE DELIVERY OF POLICY.

The printed receipt issued to the deceased by the defendant's agent for the first premium on a policy of life insurance provided that he was to be insured from the date of the receipt, if accepted by the company as an insurable risk under its rules and regulations, and stated that he was otherwise admissible on the plan and for the amount applied for. Upon its receipt by the defendant, the word "approved" was indorsed upon the application of the deceased and a policy was issued the same in every respect as that applied for, except that the amount of premium was increased, but acknowledging and treating the first premium as paid in full. The deceased committed suicide before receiving or accepting the conditional policy. *Held*, as a matter of law, that by placing the printed form of receipt in his hands, the company authorized its agent to bind them in accordance with its terms, and the company having by its action on the application approved and accepted it without such condition as amounted to a new proposition, there was a contract of temporary insurance completed in Missouri from the date of the receipt until the conditional policy issued was presented to the deceased for acceptance.

(For other cases, see Insurance, Cent. Dig. § 198; Dec. Dig. § 130[3].)

2. INSURANCE—CONSTRUCTION OF AMBIGUOUS CONTRACTS.

Insurance contracts printed and prepared by skilled insurance experts and lawyers and offered to the public, which is without special knowledge, if in any respect ambiguous or capable of two meanings, must be construed in favor of the assured.

(For other cases, see Insurance, Cent. Dig. § 294; Dec. Dig. § 146[2].)

Appeal from Circuit Court, Greene County; Guy D. Kirby, Judge.
Action by Hattie E. Kempf and others against the Equitable Life Assurance Society of the United States. From a judgment for the plaintiffs, defendant appeals. Affirmed.

Alexander & Green, of New York City, and Barbour & McDavid, of Springfield, for Appellant.

W. T. Lamkin, of Billings, Mo., and J. T. Neville and J. T. White, both of Springfield, for Respondents.

FARRINGTON, J.

The plaintiffs (respondents) recovered judgment for \$5,000 based on the following petition (formal parts omitted):—

"Now at this day come the plaintiffs herein and file this their

* Decision rendered, March 11, 1916. Rehearing denied, April 3, 1916.
184 S. W. Rep. 133.

final amended petition, leave of court being first had, and for their cause of action state:—

"That the plaintiff Anna Kempf is a minor and that F. T. Stockard has been by order of this court duly and legally appointed her next friend under the statutes of the state of Missouri and is now acting herein in that capacity; that said Anna Kempf is the daughter, and plaintiff Hattie E. Kempf is the widow, of Joseph E. Kempf, deceased.

"That the defendant is a corporation duly organized under the laws of the state of New York and engaged in the business of life insurance, with its home office in the city and state of New York, and at all times herein mentioned was duly authorized to do business as a life insurance company in the state of Missouri.

"That one of the methods or plans by which the lives of individuals are insured by insurance companies is denominated and commonly called the 'Ordinary Life Plan,' whereby the assured pays a stipulated sum of money annually or semiannually at stated periods for and during the entire life of the assured, and wherein the insurer pays to the beneficiary of the assured a stipulated sum at his death.

"That the defendant among the plans adopted and used by it in insuring the lives of individuals adopted and at the times herein mentioned was using such 'Ordinary Life Plan' of insurance, and adopted certain forms of policy or insurance contracts for such 'Ordinary Life Plan,' one of which forms containing the usual terms and conditions of such 'Ordinary Life Plan' is hereto attached and marked 'Exhibit A.'

"That on the 12th day of June, 1913, said Joseph E. Kempf applied to the defendant for a policy of insurance upon the said 'Ordinary Life Plan' in the sum of \$5,000, with plaintiffs herein as beneficiaries of such insurance, and the said Joseph E. Kempf and the defendant thereupon, on said 12th day of June, 1913, entered into a contract whereby the defendant agreed to insure and did insure the life of Joseph E. Kempf on said 'Ordinary Life Plan' and did promise to pay to plaintiffs herein in equal parts the sum of \$5,000 upon the death of said Joseph E. Kempf; that by the terms of said contract said insurance on the life of Joseph E. Kempf was to take effect and be in force from and after the said 12th day of June, 1913, provided the said Joseph E. Kempf was, on said date, in the opinion of the authorized officers of the defendant in New York, an insurable risk under the rules of said defendant, and the application of said Kempf was otherwise acceptable on the plan and for the amount applied for by him; that said contract was in writing and is shown by the application of said Joseph E. Kempf above mentioned, a copy of which is hereto attached and marked 'Exhibit B,' and a binding receipt for the first semiannual premium paid by said Kempf to defendant, a copy of which receipt was executed by M. A. Nelson, the duly authorized and acting agent of defendant, and

a copy thereof is hereto attached and marked 'Exhibit C'; that all of said acts were done in the state of Missouri and said Joseph E. Kempf was at all times herein stated a resident of the state of Missouri and expected to remain a resident of Missouri.

"That said Joseph E. Kempf on said 12th day of June, 1913, at the time of the signing of said receipt and the presentation of said application, paid to the defendant the sum of \$111.25, the amount figured and estimated by the said M. A. Nelson, agent of defendant, as the correct and proper amount to be paid by said Joseph E. Kempf for the first semiannual premium to be paid by him for said insurance on his life in the sum of \$5,000, and that pursuant to said application and said receipt a policy of insurance upon the life of said Joseph E. Kempf was by said agreement to be issued to him by defendant in the sum of \$5,000.

"Plaintiffs further say that in the opinion of the defendant's authorized officers in New York, the said Joseph E. Kempf was on the 12th day of June, 1913, an insurable risk under the defendant's rules and his said application was otherwise acceptable on the plan and for the amount applied for as aforesaid and thereby the said contract of insurance became and was in full force and effect from and after said 12th day of June, 1913.

"That said Joseph E. Kempf on the 24th day of June, 1913, departed this life while said insurance was in full force and effect, but before any policy was delivered to him by defendant, and thereby the defendant became liable to the beneficiaries named in said application, these plaintiffs, for the said sum of \$5,000.

"Wherefore plaintiffs pray judgment against the defendant for the said sum of \$5,000 and interest from the filing of this suit, together with their costs."

The answer filed set up the defense: That the assured committed suicide within one year. That the contract, if any, was a New York contract, pleading the New York laws governing suicide cases. That the policy contained the following provision: "Self-destruction, sane or insane, within one year from the date of issuance hereof is a risk not assumed by the society under this policy. In such an event the society will return the premiums actually received." That such provision in New York is a legal provision, pleading certain New York decisions on this question. That the acceptance and approval of the application and the issuance of the policy was done by the defendant's agents in New York. This part of the answer, over defendant's exception, was stricken out, and exception preserved.

That part of the answer pertinent to the issue as we see it, and which we deem decisive of the case and the theory on which the case was tried, is as follows (formal parts omitted):—

"Comes now the defendant and for its answer to plaintiffs' amended petition admits that it is a corporation as alleged in said

petition. It further admits that on June 12, 1913, Joseph E. Kempf applied to the defendant for a policy of life insurance in the sum of \$5,000, and at the same time executed to M. A. Nelson, the agent of the defendant, his promissory note in the amount of \$111.25 as and for the first semiannual premium to be due on the policy as applied for, should one be issued as per the terms of said application. * * * Further answering, the defendant denies each and every allegation in said petition contained except as hereinabove admitted to be true, and having fully answered prays to be discharged with its costs."

The facts of the case may be stated as follows:—

On June 12, 1913, Joseph E. Kempf made an application to the defendant company for \$5,000 insurance on the ordinary life plan, on which day he executed a note for \$111.25, the same representing the first semiannual premium. On the same day the defendant's agent executed and delivered the following receipt:—

"Received of Joseph E. Kempf one hundred eleven and 25/100 dollars, the first semiannual premium on proposed insurance for \$5,000 on the life of self for which the above-mentioned application is this day made to the Equitable Life Assurance Society of the United States. Insurance subject to the terms and conditions of the policy contract shall take effect as of the date of this receipt, provided the applicant is on this date in the opinion of the society's authorized officers in New York, an insurable risk under its rules and the application is otherwise acceptable on the plan and for the amount applied for; otherwise the payment evidenced by this receipt shall be returned on demand and the surrender of this receipt. [Signed] M. A. Nelson, agent. Dated at Springfield, Mo., 6/12/13."

The application for insurance, mentioned in the receipt, is the usual form of such documents, being a printed blank with printed questions to be answered and filled in by the applicant. It names the plaintiffs herein as beneficiaries, and contains the following stipulation:—

"I hereby agree that the policy issued hereon shall not take effect until the first premium has been paid during my good health."

It also contains the following:—

"I have paid to M. A. Nelson \$111.25 to cover the first semiannual premium on the policy applied for, in accordance with the provisions of the receipt of date and number corresponding to this application, which I hereby accept, and agree to the conditions thereof."

In the application Kempf stated that he used alcoholic beverages to the extent of from one to two ounces before breakfast.

The local medical examiner pronounced Kempf in good health, stated that he was a first-class risk, and recommended him for

life insurance. The forms for the application and the receipt were furnished to the defendant's agent by the defendant company. The application was received by the defendant on June 17, 1913, on which date there was made on defendant's record the notation: "Await inspection (habits). A. W. B." Inquiry was made by the defendant, and after the receipt of answers thereto the application shows the following entry thereon in New York: "June 23, 1913. Approved 5,000 age plus 45%. A. L. S." Dr. A. L. Sherill was one of the medical directors of the defendant company at the home office. The following appears under the above: "June 24, 1913. Issue O. L. age 47 plus 5 P. H. Send release. E. H." The evidence shows that "O. L." means "Ordinary Life." It is also shown that "45%" means five years added to the age of the applicant; that the applicant was "rated up"—that is, five years was added to his real age and the premium rate increased accordingly. With this change, the application was approved and the policy ordered released from the St. Louis office and delivered to the assured.

The letter sending the policy from the New York office to the St. Louis office, dated June 23, 1913, is known as a "ready letter writer"—that is, it is prepared in printed form, containing a great many orders and notations, and such as are to be used in connection with the particular policy sent are check marked. This letter is addressed to the St. Louis agent of the company, and is as follows:—

"Dear Sir: Policy on the life of Mr. Joseph E. Kempf, if the risk be accepted, will be issued subject to the conditions checked below."

And the check marks are opposite these statements:—

"Age rated up 5 yrs. b. Personal History. 20. A settlement has been taken in this case and conditional receipt issued. If policy issued is not accepted, return settlement promptly and take up receipt without fail."

It is agreed that on the 23d or 24th of June, 1913, the assured was found dead from a bullet wound and his pistol was found beside his body. There is little doubt but that he committed suicide. The company was advised of this on the 26th following, and it thereupon wired its St. Louis office that the policy was canceled and to return it.

The policy which had been written up and forwarded on the life of Kempf was for \$5,000, issued on the ordinary life plan, and corresponded in every way with the policy called for in the application and receipt except in the amount of the premium to be paid. It is explained by the officers of the defendant company that owing to the personal habits of Kempf as disclosed by his application they were unwilling to issue him a policy on the plan and for the amount desired at the rate charged applicants 47 years of age of good habits, the rate for such a person requiring a semiannual payment of \$111.25, but that they were willing to

issue to him, and in fact did write up the policy and send it for delivery to him for the amount and on the plan desired at a semi-annual premium of \$137.55; that is, the only difference between the policy which would be issued to a man 47 years of age for the amount and on this plan, and the one which was forwarded from the New York office to the St. Louis office to be delivered to Kempf, was the increase in the semiannual premium from \$111.25 to \$137.55. On the back of the policy is the notation that the semiannual premium is \$137.55, due the 12th of June and December. This was all done after the receipt had been given and after the money paid by Kempf had been received and accepted by the company's agent. Nowhere on the policy issued is there disclosed what the first semiannual premium is to be, and in the letter forwarding the policy to the St. Louis office to be delivered to Kempf there is no instruction whatever that in case the policy is delivered the assured must pay, on delivery, the difference between \$111.25 and \$137.55.

The trial court in a jury trial held that under these conditions the life of Kempf was insured for \$5,000 in the defendant company, and the defendant has appealed, contending, first, that there was never consummated a contract of insurance, and, second that it was a New York contract and that the assured's rights thereunder were forfeited by his own act.

[1, 2] As we think there was a contract of insurance dated on June 12, 1913, made and completed in Missouri, it will not be necessary to go into the second contention.

On turning to the receipt given by Nelson, defendant's agent at Springfield, to Kempf, we find that there was \$111.25 paid for the first semiannual premium on the proposed insurance of \$5,000; that:-

"Insurance subject to the terms and conditions of the policy contract shall take effect as of the date of this receipt, provided the applicant is on this date in the opinion of the society's authorized officers in New York an insurable risk under its rules and the application is otherwise acceptable on the plan and for the amount applied for; otherwise the payment evidenced by this receipt shall be returned on demand and the surrender of this receipt."

The evidence shows without question that in the opinion of the officers of the society in New York the assured was an insurable risk because they not only wrote across the application "Approved," but ordered that a policy issue thereon, and the policy issued was an ordinary life policy and for the sum of \$5,000. The applicant therefore was acceptable on the plan and for the amount applied for.

It is unnecessary for us to go into the question whether the medical examiners and officers in the New York office could whimsically refuse to accept this applicant and issue him a policy, because their admitted acts concerning the matter with which

they were dealing amounted in law to an approval and an acceptance of this applicant; that is, it shows in law that in the opinion of the officers the applicant met the conditions on which he was to be insured for \$5,000 on and from June 12, 1913, or that in their opinion he was an acceptable risk for the amount and on the plan of the date of the application.

It is a consideration which is held out to prospective customers of the company that they will be insured from the date of their application if they meet the requirements set forth in the application and receipt. Otherwise, what benefit would it be to an applicant to have his policy dated back to the date of the application provided he lived and accepted? It is to cover the period from the date of the application until a delivery of the policy that he pays his money in advance, and it cannot be said that his temporary insurance is without consideration where he is either finally rejected by the company or himself refuses to accept the policy with the increased premium and his money is handed back to him. As a first consideration, it is an inducement to get business, and then it gives the insurance company the chance to insure this man's life, for which chance it is willing to give this temporary insurance.

The law is wisely written and well settled in this state that insurance contracts, or in fact any contract, and especially insurance contracts that are printed and prepared by skilled insurance experts and lawyers and offered to the public, that is without special knowledge in this line of business, must be construed, in respects ambiguous, doubtful, or at least of two meanings, in favor of the assured. Mathews vs. M. W. A. 236 Mo. 326, 139 S. W. 151, Ann. Cas. 1912D, 483; Dezell vs. Fidelity & Casualty Co., 176 Mo. loc. cit. 266, 75 S. W. 1102; Still vs. Insurance Co., 185 Mo. App. loc. cit. 553, 172 S. W. 625.

We think there is no question that the insurance company by the receipt given contracted with Kempf that he was insured from June 12, 1913, provided he met certain conditions in the opinion of the New York officers. That he was an insurable risk is clearly shown to have been the opinion of these New York officers, and as to whether the application was acceptable was qualified and limited on the plan and for the amount applied for; it was not necessary, so far as this receipt is concerned, that it be acceptable as to the first semiannual premium. On the other hand, there is no showing in this case that the first semiannual premium, which was paid, was to be the same as other semiannual premiums falling due in December and June of each year, and indeed the interpretation that the company placed upon this contract when it forwarded the policy to its St. Louis office for delivery does not indicate that it expected Kempf, for the first semiannual premium, to make any further payment. Would it not be the natural thing, and in fact a prominent part of a letter sending the policy, to direct the agent that in case of a delivery

he must collect the difference between what had already been paid (\$111.25) and \$137.55? And yet not one word does it voice in its letter in this regard. On the contrary, the policy sent with the letter acknowledges receipt of the first premium as in full and calls for the payment of the next premium to be paid in December, 1913. This shows that the company was treating the first semiannual premium as having been paid in full because no further premium for any amount was demanded under the terms of the letter and the policy till the December payment was due.

The policy issued as to premiums contains on its face the following provisions:—

"Premiums. This insurance is granted in consideration of the payment in advance of one hundred thirty-seven and fifty-five one hundredths dollars, and of the payment semiannually thereafter of a like sum upon each 12th day of December and June, until the death of the insured."

"Age. The premiums, loans and surrender values of this policy are on the basis of the rated-up age of fifty-two years, which is five years in excess of the age stated by the insured."

We therefore could rest this case on the proposition that where there are two meanings open upon the construction of a contract of this character, we must give that construction which is most favorable to the assured. But, as hereinbefore indicated, the contract in question appears to us as plain and unambiguous, meaning only in the light of common sense and justice that Kempf was insured from the date of his application, provided he met certain conditions which must in the opinion of the officers in New York have existed as of the date of the application. That such an opinion did exist has already been referred to. Respondents cite several cases directly in point arising under almost exactly the same facts.

Such a binding receipt, so designated by the appellant, insures from its date and is recognized as a form of insurance. 1 Cooley's Briefs on the Law of Insurance, pp. 535-537; 25 Cyc. 714. The case of Lee vs. Union Cent. Life Ins. Co. (Ky.) 41 S. W. 319, deals with exactly the same question that we have here and is a case where the premium written in the policy was greater than that written in the application, and it was claimed in that case, as here, that such change amounted to a rejection of the applicant and was the making of a proposition to him. The point was ruled against the company, the court holding, as we hold here, that where no application was demanded, but the policy was issued on the application which was marked, by the officers of the company whose opinion was necessary, "Approved," and where the officers whose business it was to order the issuance of a policy approved the application for the amount and on the plan applied for, was not the making of a new proposition, and that on a showing that the assured died, the benefi-

ciary made a case. See, also, *Halle vs. New York Life Ins. Co. (Ky.) 58 S. W. 822.*

The case of *Starr vs. Mutual Life Ins. Co. of N. Y.*, 41 Wash. 228, 83 Pac. 116, was where an application stated that insurance would be in force from date "provided this application shall be approved and the policy duly signed by the secretary at the head office of the company and issued." The application was approved and the policy issued and sent for delivery. The applicant died before the approval of the application and issuance of the policy. The court in deciding the case used the following language applicable to our case:—

"By the death of Starr the subject-matter of the contract of insurance ceased to exist, and at that moment there was a contract of insurance or there was none. The approval or rejection of the application after that time would be ineffectual for any purpose. The object of the second provision of the application, above quoted, is not entirely clear, especially from the standpoint of the insured. If there was to be no contract of insurance in any event until the application was approved at the home office and a policy issued thereon, it would seem entirely immaterial to the insured whether the contract related back to the date of the application or not. If he lived until the application was approved and a policy issued, it would seem a matter of indifference to him whether he had been insured during the interim between the date of the application and the date of the issuance of the policy. On the other hand, if he died before the application was approved and the policy issued, his beneficiaries would derive no benefit from the insurance. The chief object of the provision would therefore seem to be to enable the insurance company to collect premiums for a period during which there was in fact no insurance, and consequently no risk."

Also the following language:—

"If insurance companies deem it necessary for their protection to limit the operation of their contracts of insurance from the date of issuance of the policy, or from any other date, it is very easy for them to say so and to bring knowledge of that fact home to those with whom they are dealing. In this case, we hold that the receipt given constituted a present contract of insurance, subject to be continued or terminated by the approval or rejection of the application, and that the insured was not affected by any want of authority in the soliciting agent to enter into such a contract, unless notice of such want of authority was brought home to him."

The case of *Lee vs. Union Cent. Life Ins. Co.*, *supra*, has not, so far as we can find, been overruled. However, the case of *Halle vs. New York Life Ins. Co.*, *supra*, was criticized in the case of *Northwestern Mut. Life Ins. Co. vs. Neafus*, 145 Ky. 563, 140 S. W. 1026, 36 L. R. A. (N. S.) 1211. But the case

last mentioned merely holds that the receipt given in the Halle Case was not a binding receipt, one of the conditions therein being that the insurance should first be issued. In the Neafus Case the applicant is shown to be not an acceptable risk.

We are cited to a number of fire insurance cases in respondents' brief where binding receipts for fire insurance were given. Appellant contends that fire insurance cases are not applicable to life insurance contracts, citing 1 Cooley's Briefs on the Law of Insurance, page 419, wherein it is laid down:—

"It may be stated, *as a general rule*, that agents of life insurance companies do not have authority to conclude absolutely the contract of insurance, but only to procure and receive applications, which they forward to the company to be acted upon by the immediate officers of the corporation." (Italics are ours.)

We know of no reason, however, why the same law would not apply to a life insurance contract that would apply to a fire insurance contract where the life insurance company places in the agent's hands forms which would, when filled in and signed, make a binding contract the same as in cases of fire insurance. See Horton vs. New York Life Ins. Co., 151 Mo. loc. cit. 617, 52 S. W. 356.

The case of Mohrstadt vs. Mutual Life Ins. Co. of N. Y., 115 Fed. 81, 52 C. C. A. 675, relied on by appellant, was a case where the entire plan as contemplated by the application was rejected by the company and a policy on a different plan offered. In our case, had the company when Kempf's application was received by the company's officers offered him an entirely different plan, such act alone would have shown a rejection of Kempf's original application and a new proposition made to him, which, of course, must have been accepted by him before it would be binding. Besides, the receipt in that case, required that the application be accepted by the company, whereas in our case the condition was that if the applicant was acceptable his insurance would be in force from the date of the receipt.

In the cases of Travis vs. Nederland Life Ins. Co., 104 Fed. 486, 43 C. C. A. 653, Ætna Life Ins. Co. vs. Hocker, 39 Tex. Civ. App. 330, 89 S. W. 26, Born vs. Home Ins. Co., 120 Iowa, 299, 94 N. W. 849, and Phoenix Ins. Co. vs. Schultz, 80 Fed. loc. cit. 342, 25 C. C. A. 453, no binding receipts were given. There was merely an application which amounted to nothing more than a proposition requiring action by the company before insurance began.

In the case of Steinle vs. New York Life Ins. Co., 81 Fed. 489, 26 C. C. A. 491, it was provided in the contract that if the application is not approved and accepted, the company shall incur no liability thereunder.

In the case of Mutual Life Ins. Co. vs. Young, 23 Wall. (90 U. S.) 85, 23 L. Ed. 152, the receipt recited:—

"To be in force from and after the date hereof provided the said application shall be accepted by the company."

The court there held to the terms of the receipt which required that before insurance begun the application must have been accepted. The condition in this and the other cases cited by the appellant did not depend upon the applicant's eligibility, which was the condition in our case, but upon some subsequent act to be performed by the company.

Appellant quotes copiously in its brief from the case of *Horton vs. New York Life Ins. Co.*, 151 Mo. 604, 52 S. W. 356. In that case, however, the question for decision was whether the agreement was a Missouri or a New York contract. A conditional receipt, as shown on page 614 of 151 Mo., 52 S. W. 356, was given, and in discussing this receipt (loc. cit. 620 of 151 Mo., 52 S. W. 356) the court broadly intimates that where it is shown that the agent has authority to give a binding receipt, the company could not escape liability. The court concluded (loc. cit. 621 of 151 Mo., 52 S. W. 356) because it appeared from the record that the agent had no authority to bind the company to a contract of insurance from the date of the acceptance of the application in New York, that it was not a New York contract and only became a contract upon delivery of the policy which was to be made in Missouri. An agent's authority is coextensive with his employment, and where it is admitted that the company placed in the agent's hands the forms necessary to close a binding contract with those with whom the agent would deal on behalf of the company, such act shows that he had authority to bind the company as to the terms printed in that conditional receipt and application furnished by the company and forwarded to the agent for use, where the party dealing with the agent had no knowledge of a lack of authority.

We therefore hold that by the admitted written acceptance of the application for the amount and on the plan, and the order of the officers of the corporation that a policy be issued for the amount and on the plan desired, show as a matter of law that the company regarded Kempf as an insurable risk, and that the conditions necessary to make said insurance in force from and after June 12, 1913, had been met, and that this contract, subject to the determination of his eligibility, was all a completed contract made and entered into in the state of Missouri.

For the reasons herein appearing, the judgment is affirmed.

Robertson, P. J., and Sturgis, J., concur.

KANSAS CITY COURT OF APPEALS.

MISSOURI.

TANTER*vs.*

CENTRAL STATES LIFE INS. CO. (No. 11699.)*

1. INSURANCE—CONTRACT—ISSUANCE AND DELIVERY OF POLICY.

The application for life insurance, with certificate of examination by a local physician, does not constitute a contract of insurance until, as therein provided, the application has been approved and a policy issued and delivered during the applicant's lifetime.

(For other cases, see Insurance, Cent. Dig. §§ 219, 225; Dec. Dig. § 136[1].)

2. INSURANCE—APPLICATION—ACCEPTANCE AND DELIVERY OF POLICY—WAIVER.

Plaintiff's deceased husband made a written application for life insurance through defendant's soliciting agent, and gave his negotiable note for a first year's premium, and two days afterwards underwent a medical examination, the written report of which was forwarded to the defendant, and three days afterwards was killed, and the defendant, becoming aware of his death on the following day, before approving the application or issuing the policy, refused to issue a policy. On demand of plaintiff's attorney, defendant refused to deliver the policy or the note, stating that the agent had the note which it had directed to be returned. The agent tendered the amount of the note, refused to receive it or to issue a policy, and defendant afterwards procured the note from the agent and tendered it in court for cancellation. *Held*, that there was no waiver of a formal approval of the application and the issuance of a policy thereon, so that defendant might deny any contract of insurance.

(For other cases, see Insurance, Cent. Dig. §§ 253-255; Dec. Dig. § 141[1].)

Appeal from Circuit Court, Macon County; Nat M. Shelton, Judge.
"Not to be officially published."

Action by Ethel M. Tainter, administratrix, against Central States Life Insurance Company. Judgment for defendant, and plaintiff appeals. Affirmed.

C. G. Buster and Guthrie & Franklin, all of Macon, for Appellant.
E. M. Grossman, of St Louis, and W. C. Goodson, of Macon, for Respondent.

ELLISON, P. J.

This action is based on an alleged contract of life insurance where no policy was issued, the judgment in the trial court was for the defendant.

Plaintiff's deceased husband made written application for life insurance by defendant in the sum of \$2,500. The application was taken by one of defendant's soliciting agents on the 19th of

* Decision rendered, May 1, 1916. 185 S. W. Rep. 1185.

December, 1912, and a negotiable note of that date for \$101.85, due in six months, for the first year's premium was signed by him and delivered to the agent. Two days afterwards, on the 21st of the month, deceased was examined by the defendant's physician duly authorized to do so, the examination reduced to writing, and forwarded to defendant company by the physician and received by the company on the 24th. Three days afterwards (27th of December, 1912) deceased was thrown from an automobile and instantly killed. The defendant company became aware of the death next day before approving of the application, or issuing the policy, and refused to issue a policy. Within a few days, on the 8th of January, 1913, plaintiff was appointed administratrix of deceased's estate, and notified defendant, and on the 1st of February thereafter sent her attorney to defendant's general offices in St. Louis, when, as he testified, he demanded the policy of the company's secretary, and it was refused. He then demanded the note, which also was refused, the secretary stating that the agent had possession of it. Plaintiff's attorney also testified that the secretary said that the company would decide on what it intended to do and would notify plaintiff. No notice, other than what may be inferred from what we have just stated, was ever given to plaintiff that the application had been rejected, and no offer was made to plaintiff to cancel the note or to produce it until the answer was filed in the cause. Afterwards, in October, 1913, plaintiff's attorney tendered to the soliciting agent the sum due on the note, he still having it in his possession, and demanded a policy. This was refused by the agent. Afterwards this action was brought on the theory, as stated by plaintiff, that the defendant received the application and the note for the premium and kept them, and, failing either to deliver a policy or return the note, it became liable for the amount of the insurance applied for. Defendant learned of the death of deceased from its general agent at St. Joseph, Mo., and immediately telegraphed him that no action had been taken on the application, and that hence the company was not liable, and for him to return the note. Defendant's secretary testified that he did not say to plaintiff's attorney (as the latter testified) that the company would decide on what it intended to do and would notify plaintiff. There was also evidence in defendant's behalf that the officers of the company instructed the subagent who took the application and note to return the note, and that they thought it had been done. Finally the note was gotten by the company from the soliciting agent and was tendered in court by the answer, for cancellation.

[1, 2] It was stated by plaintiff's counsel at the argument that this case, in all essential particulars, was like that of Rhodus vs. Ins. Co., 156 Mo. App. 281, 137 S. W. 907. Defendant, while conceding many of the facts are common to both cases, claims that the controlling fact in that case is absent from this. It was decided in that case, on ample authority, that the application for

life insurance with certificate of examination by local physician did not constitute a contract of insurance until, as therein provided, the applicant had been approved and a policy issued and delivered during the applicant's lifetime. But it was further decided that these conditions precedent to a valid contract could be waived by the insurer, and were waived in that case, by the company receiving and retaining the premium from its agent, with full knowledge that the applicant had died. The only support for the contention here that there was a waiver of formal approval of the application and issuance of a policy thereon is that defendant did not return the premium note. But the uncontradicted fact is that defendant refused to issue a policy, or to recognize a contract, and ordered both its general agent over the territory here involved and the soliciting agent to return the note. It is true that the evidence showed that on the failure of the company to issue a policy plaintiff tendered the money represented by the note to the soliciting agent, who refused to receive it, and refused to give up the note or to deliver a policy. Yet we do not think that fact, connected, as it is, with the other facts we have stated, should estop defendant from denying a contract of insurance.

We think it clear the circuit court rendered the proper judgment, and it is affirmed. All concur.



SUPREME COURT OF NEW YORK.
APPELLATE TERM, FIRST DEPARTMENT.

EDELSON

v.s.

METROPOLITAN LIFE INS. CO.*

1. INSURANCE—ACTIONS—EVIDENCE—ADMISSIBILITY.

Where the policy of insurance, in accordance with Insurance Law (Consol. Laws, c. 28) § 58, provided that the policy should contain the entire contract, and further that, if the insured misrepresented his age, the policy should be good only in an amount equal to that which the premium paid would purchase at his attained age, and the insured misrepresented his age, although the application was not made a part of the contract, it was admissible under the clause providing for reduction of the policy, since the defense was under the reduction clause, and not on any matter included only in the application, and if

*Decision rendered, May 9, 1916. 158 N. Y. Supp. 1018.

such defense were cut off, the policy would be void under section 89, prohibiting discriminations.

(For other cases, see Insurance, Cent. Dig. §§ 1677, 1680, 1681, 1685; Dec. Dig. § 655[2].)

2. INSURANCE—LIFE INSURANCE—POLICY—CONSTRUCTION.

A policy of life insurance must be read in connection with Insurance Law, § 58, requiring the entire contract to be expressed in the policy.

(For other cases, see Insurance, Cent. Dig. § 312; Dec. Dig. § 152[3].)

Appeal from Municipal Court, Borough of Manhattan, Seventh District.

Action by Annie Edelson against the Metropolitan Life Insurance Company. Judgment for plaintiff, and defendant appeals. Modified and affirmed.

Argued March term, 1916, before Lehman, Pendleton, and Whittaker, JJ.

Woodford, Bovee & Butcher, of New York City (James N. Luttrell, of New York City, of counsel), for Appellant.

Joseph M. Edelson, of New York City (Bertram L. Marks, of New York City, of counsel), for Respondent.

LEHMAN, J.

The plaintiff has recovered a judgment upon a policy of insurance in the sum of \$500, issued by the defendant upon the life of Isaac Levitt. The policy contains a clause that:—

“If the age of the insured has been misstated, the amount payable hereunder shall be such as the premium paid would have purchased at the correct age.”

The policy also contains on its face the words:—

“Ordinary Life, Intermediate Class. Age, 60. Amount, \$500. 1/12 Annual Premium, \$3.13.”

It appeared at the trial, practically without dispute, that the insured was sixty-six years old at the time the policy was issued; that in his application his age was stated as sixty; that the premium paid would have purchased a policy for only \$370.85 if the age had been correctly stated. The defendant admits liability for, and has paid into court, this amount less the unpaid premium for the last year. The trial justice has given judgment for the face amount of the policy less the unpaid premium, apparently on the ground that the application was not attached to the policy, and that under section 58 of the Insurance Law the application did not become part of the policy of insurance unless attached thereto.

[1, 2] The policy recites that it is issued “in consideration of the application for this policy, copy of which application is attached hereto and made part hereof”. It also provides that:—

“This policy and the application therefore constitutes the entire contract between the parties. * * * All statements made

by the insured shall, in the absence of fraud, be deemed representations, and not warranties, and no such statement shall avoid this policy or be used in defense of a claim hereunder unless it is contained in the written application therefor and a copy of such application is securely attached to this policy when issued."

These clauses of the contract must be read in connection with section 58 of the Insurance Law, and are, I think, practically a stipulation by the parties fixing their rights in the same manner as in any event and without express stipulation they would be fixed by law. I do not think, however, that they can be given the effect contended for by the plaintiff and that they prevent the court from considering the statement of the insured as to his age, though the application was not physically attached to their policy.

There can be no doubt that the insured did make a misstatement as to his age, and there can be no doubt that the amount of the policy was determined upon that statement. The parties have expressly stipulated, however, that in spite of the fact that the policy states on its face that it is for \$500, yet if the age of the insured has been misstated, the amount payable shall be such as the premium would have purchased at the correct age. Unless this clause can be enforced, the insured will receive more insurance for the premium than the parties agreed upon, and more than the parties could have agreed upon without contravention of section 89 of the Insurance Law. I cannot see any valid reason why the contract should not be enforced in accordance with the intent of the parties. To do so would not, as the plaintiff claims, make the application a part of the contract, nor permit a statement therein to be used as a defense of a claim thereunder, though not attached to the contract. The contract on its face shows that the amount payable thereunder is based upon the assumption that the insured was sixty years of age when it was issued, and it further provides that if the age has been misstated the amount payable shall be such as the premium paid would have purchased at the correct age.

The defendant does not now seek to interpose any representation in the application as a defense to the claim under the contract, nor does it seek to incorporate the application into the contract. It stands upon the actual contract itself, and the application is material and competent evidence to show that the contingency has occurred which makes effective the clause that the amount payable shall be such as the premium would have purchased at the correct age. In other words, as I read the contract, it expressly provides for a payment of \$500 upon the death of the insured based upon the assumption that the age of the in-

sured is sixty, or a payment of the amount which the premium would purchase if the age has been misstated. That contract represents the whole agreement of the parties, and there is nothing either in the express contract or in the statute which precludes the defendant from showing by proof outside of the contract that the contingency agreed upon has occurred.

It follows that the judgment should be reduced to the sum of \$344.87, with appropriate costs in the court below, and, as modified, affirmed, with \$25 costs to the appellant. All concur.



SUPREME COURT OF NEW YORK.

TRIAL TERM, ERIE COUNTY.

FORYCIARZ

vs.

PRUDENTIAL INS. CO. OF AMERICA.*

**1. INSURANCE—LIFE INSURANCE—ASSIGNMENT OF POLICY
—VALIDITY AGAINST INSURED.**

An assignment of her industrial life insurance policy by a married woman to secure money to return to her native country in Europe is good as against the insured.

(For other cases, see Insurance, Cent. Dig. §§ 481, 482; Dec. Dig. § 212.)

**2. INSURANCE—LIFE INSURANCE—ASSIGNMENT OF POLICY
—ESTOPPEL TO DISPUTE VALIDITY.**

A husband, who shared in the benefits of his wife's assigning of her policy of industrial life insurance to secure money to take the husband, herself, and their child back to Europe, is estopped from disputing the validity of the assignment.

(For other cases, see Insurance, Cent. Dig. §§ 481, 482; Dec. Dig. § 212.)

**3. INSURANCE—LIFE INSURANCE—ASSIGNABILITY OF
POLICY.**

Ordinarily a policy of life insurance is assignable as any other chose in action.

(For other cases, see Insurance, Cent. Dig. § 468; Dec. Dig. § 199.)

**4. INSURANCE—LIFE INSURANCE—ASSIGNABILITY OF
POLICY.**

A policy of life insurance may be legally assigned in New York to one not having an insurable interest in the life of insured.

(For other cases, see Insurance, Cent. Dig. §§ 166, 167; Dec. Dig. § 121.)

* Decision rendered, March, 1916. 158 N. Y. Supp. 834.

5. INSURANCE—LIFE INSURANCE—ACTION FOR BENEFIT—NECESSITY OF ASSIGNMENT.

Where a party furnishes money in an emergency to one whose life is insured, and has no assignment of the life insurance policy, he cannot maintain an action against the insurer to recover the benefit under the policy.

(For other cases, see Insurance, Cent. Dig. § 1485; Dec. Dig. § 583[2].)

6. INSURANCE—LIFE INSURANCE—ASSIGNMENT OF POLICY—RIGHT OF ASSIGNEE.

Where an industrial life policy provided it should be void if assigned, and that the company might make any payment provided for to any relative by blood, etc., or to any person appearing to be equitably entitled by reason of having incurred expense on behalf of insured, being intended to enable insured to raise money in an emergency, and insured, a married woman, assigned such policy in return for the advancement of funds to pay the transportation of herself, husband, and child back to their native country in Europe, the assignee of the policy, upon the death of the insured, was entitled to the insurance money.

(For other cases, see Insurance, Cent. Dig. §§ 1452, 1476-1478, 1482, 1485; Dec. Dig. § 593[1].)

7. INSURANCE—LIFE INSURANCE—ACTS AND REPRESENTATIONS OF AGENTS.

While the agents of life insurance companies cannot waive or alter the clear recitals or provisions contained in policies, their acts and representations may be considered as to the companies' interpretation of policies.

(For other cases, see Insurance, Cent. Dig. §§ 313, 354; Dec. Dig. § 155.)

8. INSURANCE—LIFE INSURANCE—ACTIONS—EVIDENCE.

In an action against a life insurance company by the assignee of an industrial life policy, in which the company set up that an assignment, by the provisions of the policy, avoided it, the company's act, in sending out to its local agency checks payable to insured, while not a waiver or amounting to an estoppel, could be considered in determining how the company itself interpreted the policy, with all the facts before it.

(For other cases, see Insurance, Cent. Dig. §§ 313, 354; Dec. Dig. § 155.)

9. INSURANCE—LIFE INSURANCE—ASSIGNMENT DESTROYING VALIDITY—VALIDITY OF ASSIGNMENT.

Where a policy of life insurance provided that it should be void if assigned or otherwise parted with, the insurer could destroy the validity of an assignment only by declaring the policy itself void, and recognized the validity of the policy by accepting proofs of death without objection, by attempting to make payment to the public administrator, and by attacking the assignment only.

(For other cases, see Insurance, Cent. Dig. § 1027; Dec. Dig. § 388[3].)

10. INSURANCE—LIFE INSURANCE—CONSTRUCTION OF POLICY.

All conditions and provisions favorable to the insurer by life policy, the language of which is that of the insurer, are to be strictly construed, and any ambiguity, if the policy is reasonably susceptible of two constructions, is to be resolved in favor of the insured.

(For other cases, see Insurance, Cent. Dig. § 295; Dec. Dig. § 146[3].)

Action by Josefa Foryciarz against the Prudential Insurance Company of America. On defendant's motion to set aside verdict for plaintiff, rendered upon direction, and for dismissal of the complaint on the merits. Motion denied, and plaintiff permitted to enter judgment.

Golding & Sherman, of Buffalo, for Plaintiff.
Roland Crangle, of Buffalo, for Defendant.

ROWLAND L. DAVIS, J.

On February 13, 1911, the defendant issued a policy of insurance for \$204 upon the life of one Regina Nec, a young Austrian woman living with her husband in Buffalo. It was what is known as an "industrial policy," the premium of ten cents being payable weekly. The printed form of the policy makes the "amount of benefit" payable to the executors or administrators of the insured, unless payment is made by the company to a relative or certain other persons "equitably entitled to the same by reason of having incurred expense on behalf of the insured."

The insured could neither read nor write. Her husband was a laborer; and after a child was born to them it was decided that they would go back to Austria, probably for a visit. To raise the money to go, the insured assigned her policy to her friend, the plaintiff, who bought for the insured, her husband, and child transportation to their former home. They were advised by the agent of the company that this assignment was permissible, and there was some evidence that this instruction was given by the superintendents of the company to agent, and was communicated to prospective insurers when they were solicited to take out these policies. The testimony taken by the stenographer has not been furnished on this motion, and I am stating the evidence from my own minutes, taken on the trial, and from memory.

After receiving the assignment, plaintiff paid the premiums for several months, until or after the death of the insured, which occurred at her old home in Austria. The husband and child apparently have remained in that country. The plaintiff duly filed with the company proof of the death of the insured made out on the form furnished by the defendant. This was accompanied by the written assignment of the policy to plaintiff. The company shortly afterward, with full knowledge of the facts, audited the claim and forwarded the checks to one of its superintendents in Buffalo, to be delivered to the plaintiff. The policy was stamped "Paid." The checks were not delivered to the plaintiff by the superintendent.

After a long interval the checks were returned by the superintendent to the company, and eventually a check was drawn and sent on by the company, payable to the public administrator, before a claim for the sum payable by the terms of the policy was

made by him. The husband and next of kin of the insured did not reside in Buffalo, and were making no claim, and it may be that the act of the public administrator in making a claim was inspired by some overofficial local superintendent of the defendant. The checks were delivered to the public administrator, and no effort was made by the defendant to compensate the plaintiff in any way, either for the money she had advanced when she took the assignment, or for the premiums she had paid.

[1] From the statement of facts it may readily be seen that the merits are entirely with the plaintiff. She had advanced the money, so the insured and her family could go back to their old home, where the former died and was buried. The assignment is good as against the insured. *Kimball vs. Lester*, 43 App. Div. 27, 59 N. Y. Supp. 540; *Spencer vs. Myers*, 150 N. Y. 269, 44 N. E. 942, 34 L. R. A. 175, 55 Am. St. Rep. 675.

[2] The husband is the person who would be entitled to claim practically all the funds in the hands of the public administrator (Code Civ. Proc. § 2670; Decedent Estate Law [Consol Laws, c. 13] §§ 98, 100), and he, having shared in the benefit, would be estopped from disputing the validity of the assignment. There is no evidence that there were any debts of the insured, so that the public administrator would have no method of distributing the assets of this estate which the defendant has thrust upon him. Had the plaintiff not kept up the premiums, the policy would have lapsed, and there would be no assets.

The principal defense to this action is that by its terms the policy could not be assigned. Article 3 of "provisions" is in part as follows:—

"*Policy, When Void.*—This policy shall be void * * * if the policy be assigned or otherwise parted with."

[3, 4] Ordinarily a policy of life insurance is assignable like any chose in action. *St. John vs. American Mutual Life Ins. Co.*, 13 N. Y. 31, 64 Am. Dec. 529; *Olmstead vs. Keyes*, 85 N. Y. 593; *Cannon vs. Northwestern Mutual Life Ins. Co.*, 29 Hun, 470. In this state it may even be legally assigned to one not having an insurable interest in the life of the insured. *Steinback vs. Diepenbrock*, 158 N. Y. 24, 52 N. E. 662, 44 L. R. A. 417, 70 Am. St. Rep. 424. So that, when the insured made the assignment to the plaintiff, the parties were exercising recognized legal rights, unless the terms of the policy positively and explicitly forbade it. The policy is payable "unto the executors or administrators of the insured, unless settlement shall be made as provided in article 2 under the head of 'provisions' below, immediately upon receipt of due proof of the death of the insured during the continuance of this policy." Article 2 of the "Provisions," referred to, is as follows:—

"*Facility of Payment.*—The company may make any payment provided for in this policy to any relative by blood or connection by marriage of the insured, or to any other person appearing to

said company to be equitably entitled to the same by reason of having incurred expense on behalf of the insured, for his or her burial, or if the insured be more than fifteen years of age at the date of this policy, for any other purpose, and the production by the company of a receipt signed by any or either of said persons or of other sufficient proof of such payment to any or either of them, shall be conclusive evidence that such benefits have been paid to the person or persons entitled thereto, and that all claims under this policy have been fully satisfied."

These industrial policies are for small amounts and have small weekly premiums. They are sold usually to laboring people of small means. One great purpose of the "facility of payment" provision must be to afford a ready method of raising money for the benefit of the insured, to pay funeral expenses at the time of death, or to furnish medical assistance or some other relief in the last illness, or to have the policy an asset in the hands of the insured in any emergency in life, so that funds for something other than ordinary purposes may be provided. It is also of advantage that a payment may be made to a person other than the administrator or executor; in cases where there is no estate except the policy, the delay and expense incident to the appointment of such officers may be avoided. We may readily see that these would be strong arguments to be used by agents in selling this kind of insurance to this class of customers; and we find these arguments were used among the people where the insured resided.

Under the terms of the policy there are several possible payees: First, the executor or administrator; second, any relative by blood or connection by marriage; third, any other person equitably entitled to the same by having incurred expense for her burial, or, if the insured is more than fifteen years of age, for any other purpose. Who is entitled to select the beneficiary? Always it is the insured, so long as the selection falls within any permissible class. The company should have no right to select a beneficiary, particularly if it contravenes the expressed wish of the insured. The option contained in the policy should be exercised by the company only where the insured has failed to make a choice.

[5] The company gives the insured a permissible list of payees; it furnishes a policy of insurance which it claims may be of value to pay funeral expenses, or an asset in the hands of the insured when an emergency arises. How does it expect the insured to utilize these privileges? If a volunteer furnishes money in an emergency and has no assignment, he cannot maintain an action to recover the benefits under the policy. Ferretti vs. Prudential Ins. Co., 49 Misc. Rep. 489, 97 N. Y. Supp. 1007; Marzulli vs. Metropolitan Ins. Co., 79 N. J. Law, 271, 75 Atl. 473. The only way for the insured to avail herself of the benefit of the policy, under the circumstances, was to assign it, and give to her friend

who had advanced money some assurance of remuneration. Otherwise the latter's opportunity for being reimbursed would depend entirely upon the caprice of the company or of some superintendent. By assignment the insured may prevent the payment to a claimant who is unworthy. It cannot seriously be contended that it would be wise to give such an arbitrary power to select the beneficiary to the insurer, and deny a right of choice to the insured. That would furnish opportunity for corruption and improper conduct by unscrupulous agents and superintendents. *Shea vs. U. S. Industrial Ins. Co.*, 23 App. Div. 53, 48, N. Y. Supp. 548. To do so would be to make valueless, to a large extent, the opportunity given by the terms of the policy to the insured to provide money at a time of illness or approaching death; it would defeat the manifest purpose of the provision in question, and make it extremely hazardous for any friend to furnish money to the insured in any necessity, in reliance upon the chances of repayment from the only asset the insured might have.

[6] The plaintiff falls within the class of persons "equitably entitled to payment" under the terms of the policy. In other words, she is one of the very persons contemplated as payees when the company issued this policy. The insured selected her as beneficiary by making the assignment. An assignment must have been within the contemplation of the parties when the policy was issued. When the company attempted to restrict the assignment of the policy, in article 3 as above quoted, it must be assumed it did so only as to persons not having an insurable interest, or who did not fall within the classes of permissible payees, and to prevent advantage being taken of rightful beneficiaries by claimants who were impostors and without merit. But to hold that the policy was not assignable under the circumstances recited would be to subtract much from the value of the policy to the insured, and to render nugatory the purpose of the provisions of the policy permitting the insured to raise money in an emergency.

[7] The plaintiff has recognized that these policies are assignable by its conduct. Agents cannot waive or alter the clear recitals or provisions contained in policies. *Gorman vs. Metropolitan Life Ins. Co.*, 158 App. Div. 682, 143 N. Y. Supp. 1063; *Legnard vs. Standard Life & Accident Ins. Co.*, 81 App. Div. 320, 81 N. Y. Supp. 516; *Elsner vs. Prudential Ins. Co.*, 13 Misc. Rep. 395, 34 N. Y. Supp. 246. But their acts and representations may help in showing the company's interpretation of the policies. *Shea vs. United States Industrial Ins. Co.*, 23 App. Div. 53, 48 N. Y. Supp. 548. There is some evidence that agents, with the knowledge of the superintendents, were representing that such policies could be used as an asset in times of need.

[8] The company gave recognition to valid assignments when it furnished a blank for proof of death which has a heading:

"Information to be furnished where claimant is other than father or mother, brother or sister, husband or wife." We find in line 4 of the blank in question: "Has claimant a beneficiary form or assignment of any kind?" The next line reads: "If so, attach the same to the claim papers." The claimant answered the question, "Yes," and attached the assignment. The defendant then made out and sent on its checks payable to the plaintiff. What does the defendant mean by asking for the assignment? If it regarded the policy as nonassignable, it would not make such an inquiry. The company's act in sending on checks payable to the insured, while not a waiver or amounting to estoppel, may be considered in determining how the defendant itself interpreted the policy with all the facts before it.

[9] In the provision prohibiting assignments, it is stated that the *policy* is void "if the policy be assigned or otherwise parted with." The defendant does not here seek to declare the policy void. It seeks only to declare the assignment void. The company has recognized the validity of the policy by accepting proofs without objection and attempting to make payment to the plaintiff, and by making payment or attempting to make payment to the public administrator. It has no power to declare an *assignment* void. The only way to destroy the validity of an assignment under the terms of the policy was to declare the policy itself void.

[10] The language of the policy being that of the company, all the conditions and provisions favorable to the company are to be strictly construed; and if the policy is reasonably susceptible of two constructions, the ambiguity is to be resolved in favor of the insured. 25 Cyc. 739. In *Columbia Bank vs. Equitable Assurance Society*, 61 App. Div. 594, 70 N. Y. Supp. 767, Patterson, J., says:—

"It is manifestly the duty of the insurance company to pay the amount due upon the policy to the real owner of it, or to whomsoever may have acquired a paramount lien upon it or money payable under and according to its terms."

Applying that doctrine to the facts here, we find that the plaintiff is entitled to receive payment. In *Heffernan vs. Prudential Insurance Co.*, 88 Misc. Rep. 93, 150 N. Y. Supp. 644, where in an action on a similar policy the Appellate Term held that the plaintiff's complaint should have been dismissed, different questions were presented, and the facts were apparently entirely different from those disclosed here.

In reaching the conclusion that I have, I have not regarded it necessary to discuss one significant memorandum, made apparently in the office of the company on the face of the form of the proof of death. This comes under the head of "Synopsis of Claim Department Examination." The memorandum is as follows:—

"Draw two checks, one for \$104.00, to be indorsed and returned, and one for the balance to claimant."

A legitimate inquiry might perhaps be made as to why the larger check was to be indorsed by the claimant and returned to the company. Was the company, under its alleged option, selecting itself as the principal beneficiary?

The motion to set aside the verdict and for a dismissal of the complaint must be denied, and the plaintiff may enter judgment.



METROPOLITAN LIFE INS CO. vs. GOODMAN.

(3 Div. 193.)*

(Supreme Court of Alabama.)

1. INSURANCE—ACTION—ANSWER—LIFE INSURANCE— BREACH OF WARRANTY.

Under Code 1907, § 4572, providing that no misrepresentation or warranty shall invalidate a policy of life insurance unless made with intent to deceive or unless it increased the risk, it is not enough for the plea to allege that the assured falsely warranted that he had not been attended by a physician for a serious disease for a given period; neither of the statutory conditions being thereby fulfilled.

(For other cases, see Insurance, Cent. Dig. §§ 1617, 1618, 1628; Dec. Dig. § 640[2].)

2. INSURANCE—LIFE INSURANCE—MISREPRESENTATION— REGULATORY STATUTES—CONSTRUCTION.

Code 1901, § 4572, relating to sufficiency of false representations or warranties to vitiate the policy, must be given a liberal construction in favor of the insured.

(For other cases, see Insurance, Cent. Dig. § 539; Dec. Dig. § 250[1].)

3. INSURANCE—LIFE INSURANCE—ACTIONS—DEFENSES— PLEADING.

A plea alleging that the insured fraudulently suppressed the fact that he had been attended by a physician for a serious disease, though good under Code 1907, § 4299, relating to suppression of truth, is demurable where it fails to allege intent to deceive as required by section 4572.

(For other cases, see Insurance, Cent. Dig. §§ 1617, 1618, 1628; Dec. Dig. § 640[2].)

Appeal from City Court of Montgomery; Gaston Gunter, Judge.

Action by Nancy E. Goodman against the Metropolitan Life Insurance Company to recover upon the policy issued on the life of Louis M. Goodman under which she was the beneficiary. Judgment for plaintiff,

* Decision rendered, Jan. 13, 1916. Rehearing denied, March 23, 1916.
71 South. Rep. 409.

and defendant appeals. Transferred from the Court of Appeals under section 6, Acts of 1911, p. 449. Affirmed.

Steiner, Crum & Weil, of Montgomery, for Appellant.
Letcher, McCord & Harold, of Montgomery, for Appellee.

SOVEREIGN CAMP OF WOODMEN OF THE WORLD
vs. WARD. (3 Div. 215.)*

(Supreme Court of Alabama.)

1. INSURANCE—ACTIONS—COMPLAINT.

In a suit on a life insurance contract, the complaint must show that the liability accrued within the period covered by the policy.

(For other cases, see Insurance, Cent. Dig. § 1996; Dec. Dig. § 815[1].)

2. INSURANCE—FRATERNAL BENEFIT INSURANCE—COMPLAINT—SUFFICIENCY.

A complaint, claiming from a fraternal benefit company the sum due on a certificate of insurance issued by defendant on a certain date by death of insured, and averring that the insured died on a certain date, by which defendant agreed to pay to plaintiff the sum of \$2,000 upon the death of insured, and averring that the insured died on a certain date, which was within eight months of the issuance of the certificate, that the defendant had notice of his death, and that the certificate of insurance was the property of the plaintiff, is not demurrable.

(For other cases, see Insurance, Cent. Dig. § 1996; Dec. Dig. § 815[1].)

9. INSURANCE—FRATERNAL BENEFIT INSURANCE—ADMISIBILITY OF EVIDENCE—SUICIDE.

In an action on a fraternal benefit insurance certificate where the defense was suicide, evidence that deceased was addicted to drinking immediately preceding his death was competent, in connection with evidence as to his efforts and purpose to abstain therefrom.

(For other cases, see Insurance, Cent. Dig. § 2003; Dec. Dig. § 818[4].)

10. INSURANCE—FRATERNAL BENEFIT INSURANCE—SUICIDE—QUESTION FOR JURY.

In an action on a fraternal benefit certificate, evidence held sufficient to take to the jury the question whether assured committed suicide.

(For other cases, see Insurance, Cent. Dig. § 2009; Dec. Dig. § 825[3].)

Appeal from Circuit Court, Butler County; A. E. Gamble, Judge. Action by Nettie B. Ward against Sovereign Camp of the Woodmen of the World. Judgment for the plaintiff, and defendant appeals. Reversed and remanded.

C. H. Roquemore and E. T. Graham, both of Montgomery, and C. F. Winkler, of Greenville, for Appellant.

Powell & Hamilton, of Greenville, for Appellee.

* Decision rendered, Feb. 10, 1916. Rehearing denied, March 30, 1916,
71 South. Rep. 404.

CUNNINGHAM *vs.* NATIONAL AMERICANS. (No. 353.)*
(Supreme Court of Arkansas.)**INSURANCE—FRATERNAL INSURANCE—FALSE ANSWER IN APPLICATION.**

Where insured stipulated, in his application for insurance to a fraternal benefit society, that his answers to questions propounded to him by the examining physician should be true, and warranties, and form the basis of the contract, and the contract of insurance in express terms made the application a part of it, and by the express terms of the benefit certificate answers to questions asked by the medical examiner were held to be warranties, and insured stated in his application that he had had no illness, constitutional disease, or injury confining him to the house during the past five years, while in fact he had been confined for a month or more to the hospital within five years, the insurer was not liable for the death benefit.

(For other cases, see Insurance, Cent. Dig. § 1863; Dec. Dig. § 723[5].)

Appeal from Circuit Court, Pulaski County; G. W. Hendricks, Judge.

Action by J. C. Cunningham, administrator, against the National Americans. From a judgment for defendant, plaintiff appeals. Judgment affirmed.

Tellier & Biggs, of Little Rock, for Appellant.
Bradshaw, Rhoton & Helm, of Little Rock, for Appellee.

* Decision rendered, April 24, 1916. 185 S. W. Rep. 786.

**EMINENT HOUSEHOLD OF COLUMBIAN WOODMEN
vs. HEWITT. (No. 221.)***
(Supreme Court of Arkansas.)**1. INSURANCE—FRATERNAL INSURANCE—POLICY—FUTURE CHANGE OF BY-LAWS.**

Where either the benefit certificate itself or the constitution and by-laws in existence at the issuance of the policy contained a stipulation for future changes, they might be made, and, when made, applied to pre-existing contracts.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[1].)

2. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—PROOF OF INJURY—AMENDED BY-LAWS.

In an accident benefit certificate or policy issued when the insurer's by-laws provided a payment of \$200 to a beneficiary suffering a fracture of the arm; reciting its issuance in consideration of the insured's compliance with the by-laws existing or thereafter legally amended, and an amendment providing that in the event of fracture satisfac-

* Decision rendered, March 6, 1916. 184 S. W. Rep. 52.

tory proof should be furnished the insurer, and that satisfactory proof in such case should be taken to mean an X-ray photograph, made and certified to by the insurer's physician, the insured was required to submit to an examination by the insurer's physician and to furnish an X-ray photograph with his proof of loss, but was not concluded by the fact that such photograph did not show the fracture claimed, and might prove that fact by any other competent evidence.

(For other cases, see Insurance, Cent. Dig. §§ 1963, 1964; Dec. Dig. § 789[1].)

**3. INSURANCE—F R A T E R N A L B E N E F I C I A R Y I N S U R A N C E—
S U F F I C I E N C Y O F E V I D E N C E—I N J U R Y .**

In a suit on an accident certificate, evidence on the issue of the fracture alleged to have been sustained held to support a judgment for the insured.

(For other cases, see Insurance, Dec. Dig. § 819[4].)

Appeal from Circuit Court, Howard County; Jeff. T. Cowling, Judge. Action by A. J. Hewitt against the Eminent Household of Columbian Woodmen. Judgment for plaintiff, and defendant appeals. Affirmed.

W. A. Roane, of Atlanta, Ga., and W. C. Rodgers, of Nashville, for Appellant.

D. B. Sain, of Nashville, and T. D. Crawford, of Little Rock, for Appellee.



KNIGHTS OF HONOR OF THE WORLD vs. EPPS.

(No. 337.)*

(Supreme Court of Arkansas.)

**1. INSURANCE—M U T U A L B E N E F I T I N S U R A N C E—A C T I O N
F O R D E A T H—S E R V I C E O F P R O C E S S .**

Under Kirby's Dig. § 4378, relating to service of process in suits upon policies or certificates of insurance against fraternal orders, and providing that service upon the chief officer, or in his absence on the secretary, of the subordinate lodge or society through which the policy was issued, or on the chief officer, or in his absence on the secretary, of any subordinate lodge in the state of such fraternal society, shall be valid service, absence of the chief officer meaning absence from the county, a service of summons upon the reporter or collector of a subordinate lodge, of the defendant, who had no duties that required him to write to the grand lodge, and while the chief officer of the lodge was not out of the county, was not valid.

(For other cases, see Insurance, Cent. Dig. § 1995; Dec. Dig. § 814.)

Appeal from Circuit Court, Drew County; Turner Butler, Judge.

Action by Eliza J. Epps against the Knights of Honor of the World. From a judgment denying a motion to vacate a judgment for plaintiff, and dismissing a writ of garnishment, defendant appeals. Reversed and remanded.

* Decision rendered, April 17, 1916. 185 S. W. Rep. 470.

Henry & Harris, of Monticello, and Scipio A. Jones, of Little Rock,
for Appellant.
R. W. Wilson, of Monticello, for Appellee.

NATIONAL LIFE & ACCIDENT INS. CO. *vs.* LANGFORD.

(No. 261.)*

(Supreme Court of Arkansas.)

2. INSURANCE—LIFE INSURANCE—FRAUD—QUESTION FOR JURY.

On evidence in an action on a policy of life insurance, *held*, that whether insured at the time the policy was delivered was in such condition of health as met its express conditions was for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1737-1740; 1758-1760; Dec. Dig. § 668[7].)

Appeal from Circuit Court, Nevada County; Geo. R. Haynie, Judge. Action by Alice Langford against the National Life & Accident Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Horace E. Rouse, of Prescott, for Appellant.
H. B. McKenzie, of Prescott, for Appellee.

* Decision rendered, March 20, 1916. 185 S. W. Rep. 266.

MUTUAL AID UNION ET AL. *vs.* BLACKNALL. (No. 339.)*

(Supreme Court of Arkansas.)

1. INSURANCE—MUTUAL BENEFIT INSURANCE—ACTION—RIGHT TO MAINTAIN.

Kirby's Dig. § 4377, provides that, when any death has occurred of any person whose life shall have been insured, the beneficiary or his assigns may maintain an action against the insurance company in the county of the residence of the party whose life was insured or in the county where death occurred. The residence of a member of a fraternal insurance order in which death occurred was in a county other than that of the principal office of the order or the residence of sureties on the order's bond. *Held* that, under the statute, which was made broad enough to include all insurance companies, the action against both the insurer and the sureties might be instituted in the county of the member's residence.

(For other cases, see Insurance, Cent. Dig. §§ 1536-1539; Dec. Dig. § 618.)

* Decision rendered, April 17, 1916. 185 S. W. Rep. 465.

2. INSURANCE—FRATERNAL INSURANCE—STATUTE.

Kirby's Dig. § 4348, providing that the insurance laws of the state shall be construed so as not to apply to any mutual aid society in the state for the relief of members, is not based on a subscribed or paid-up capital, but alone upon membership dues, and which also provides for the bonds to be given and the periods of their renewal to entitle insurance companies to do business in the state, but does not undertake to deal with the subject of service of process upon mutual companies, does not apply to service of process upon such company.

(For other cases, see Insurance, Cent. Dig. § 1572; Dec. Dig. § 626.)

3. INSURANCE—INSTRUCTIONS—REFUSAL.

In an action on an insurance certificate, where there was evidence that some years before issuance of the certificate the member was told by another agent that he was too old to become a member of the order, instructions submitting the question whether the member was guilty of fraud in procuring the issuance of the certificate should be given, notwithstanding it was the beneficiary's contention that the agent taking the application was the only one guilty of fraud.

(For other cases, see Insurance, Cent. Dig. §§ 1774-1776; Dec. Dig. § 669[6].)

Appeal from Circuit Court, Logan County; Jas. Cochran, Judge.

Action by Emma L. Blacknall against the Mutual Aid Union and others. From a judgment for plaintiff, defendants appeal. Reversed and remanded.

Appellants, pro se.

J. H. Evans, of Booneville, for Appellee.

VAWTER vs. PURDY ET AL. (Civ. 1728.)*

(California District Court of Appeal, Second District.)

2. INSURANCE—MUTUAL BENEFIT INSURANCE—CHANGE OF BENEFICIARY.

A member of a mutual benefit insurance association has the right in the absence of restrictive provisions of the charter, by-laws, or rules under which the association operates, to revoke his designation of a beneficiary and substitute a different one.

(For other cases, see Insurance, Cent. Dig. § 1946; Dec. Dig. § 780.)

3. INSURANCE—MUTUAL BENEFIT INSURANCE—BENEFICIARIES—VESTED INTEREST.

The beneficiary of a policy of insurance in a mutual benefit company is possessed of but an expectancy, and acquires no vested interest in the benefit funds until the death of the member.

(For other cases, see Insurance, Cent. Dig. § 1949; Dec. Dig. § 783.)

4. INSURANCE—MUTUAL BENEFIT INSURANCE—INSURABLE INTEREST OF BENEFICIARY.

Where the deceased applied for insurance in a mutual benefit association in his own behalf and paid his obligations as a member of the fund, his contract specifically permitting him to select as a beneficiary any friend, in the absence of statute, the person named as beneficiary by

* Decision rendered, Feb. 9, 1916. 157 Pac. Rep. 556.

him was eligible, although not sustaining any blood relationship to him.
(For other cases, see Insurance, Cent. Dig. §§ 1932, 1937, 1938; Dec. Dig. § 769.)

5. INSURANCE—INSURABLE INTEREST.

In the absence of any statute or contract restricting the right of the insured as to classes of persons from whom he may select his beneficiary, the utmost freedom of choice in that regard exists.

(For other cases, see Insurance, Cent. Dig. § 1939; Dec. Dig. § 773.)

Appeal from Superior Court, Los Angeles County; Curtis C. Leger-ton, Judge.

Action by Isabelle L. Vawter against F. T. Purdy and others. From a judgment for the defendant Mary C. Bassett as against the other defendants, the plaintiff appeals. Affirmed.

E. J. Fleming and B. F. Woodard, both of Los Angeles, for Appellant.

Hahn & Hahn and W. R. Hervey, all of Los Angeles, for Respondents.



ESTES ET AL. vs. LOCAL UNION, No. 43, UNITED BROTH- ERHOOD OF CARPENTERS AND JOINERS OF AMERICA.*

(Supreme Court of Errors of Connecticut.)

1. INSURANCE—BENEFITS—RIGHTS OF ESTATE OF INSURED. Upon the death of a member of a mutual benefit society, no right to funeral benefit payments passes to his estate.

(For other cases, see Insurance, Cent. Dig. § 1973; Dec. Dig. § 795.)

2. INSURANCE—CHANGE OF BENEFICIARY.

During the life of a member of a benefit society, he has the power of designation of a beneficiary of funeral benefits, including power to change a designation made, subject to statute or the restrictions of the society.

(For other cases, see Insurance, Cent. Dig. § 1946; Dec. Dig. § 780.)

3. INSURANCE—CHARTER PROVISIONS AS TO BENEFICIARY. A charter limitation of beneficiaries to "wife or legal heirs as named in his application" does not limit the member's right of designation to one to be exercised at the time of application.

(For other cases, see Insurance, Cent. Dig. §§ 1935, 1937; Dec. Dig. § 771.)

4. INSURANCE—MUTUAL BENEFIT INSURANCE—CONSTRUC- TION OF CONTRACT.

The provisions of the constitution of a benefit society, if ambiguous, should be given that construction which is most favorable to the member.

(For other cases, see Insurance, Cent. Dig. §§ 1870-1872; Dec. Dig. § 726.)

* Decision rendered, April 19, 1916. 97 Atl. Rep. 326.

5. INSURANCE—BENEFITS—MODE OF CHANGING DESIGNATION OF BENEFICIARY.

A designation of a person as the beneficiary "of all benefits or money payable from said Brotherhood," held to sufficiently designate him as beneficiary of benefits from the treasury of a local union as well as from the treasury of the main society, where all members of the local union were ipso facto members of the Brotherhood.

(For other cases, see Insurance, Cent. Dig. § 1939; Dec. Dig. § 773.)

6. INSURANCE—MUTUAL BENEFIT INSURANCE—NOTICE OF CHANGE OF BENEFICIARY.

That notice of deceased's change of designation of beneficiary is not given to the society until after his death, where no payment of benefit has been made, does not affect the validity of the designation.

(For other cases, see Insurance, Cent. Dig. §§ 1950-1952; Dec. Dig. § 784[1].)

Appeal from City Court of Hartford; Herbert S. Bullard, Judge.

Action by Annis Estes and others against Local Union, No. 43, United Brotherhood of Carpenters and Joiners of America. From a judgment for plaintiffs, defendant appeals. No error.

Henry H. Hunt and Nathan A. Schatz, both of Hartford, for Appellant.

George O. Brott, of Hartford, for Appellee.

**AMERICAN NAT. INS. CO. vs. DAVIS. (No. 6683.)***

(Court of Appeals of Georgia.)

1. WAGERING—CONTRACT OF INSURANCE.

The two real questions in this case are: (1) Was the contract of insurance sued upon procured by the sister (who was also the beneficiary) of the insured under such circumstances as to make it a wagering contract, or was the policy taken out by the insured himself? (2) Did the insured, at the time of the issuance of the policy, make to the insurance company any material false and fraudulent representations as to the present and previous state of his health? These questions of fact with appropriate instructions thereon, were properly submitted to the jury, and there was evidence to sustain their finding.

2. REFUSAL OF NEW TRIAL.

No material error of law appears, and the court did not err in overruling the motion for a new trial.

Error from City Court of Waycross; Jno. C. McDonald, Judge.

Action by Henrietta Davis against the American National Insurance Company. Judgment for plaintiff, and defendant brings error. Affirmed.

J. L. Sweat, of Waycross, for Plaintiff in Error.

Parker & Walker, of Waycross, for Defendant in Error.

* Decision rendered, April 17, 1916. 88 S. E. Rep. 593. Syllabus by the Court.

CHEWNING vs. TUCKER. (7057.)*

(Court of Appeals of Georgia.)

2. INSURANCE—NOTE FOR PREMIUM—LIABILITY.

The uncontradicted testimony shows that the note sued upon was given in payment of the first premium on a policy of insurance, which was still in the possession of the defendant in the court below, who himself testified that he was then insured and was then in possession of the policy for which the note was given. Under the rulings made in Thomson vs. McLaughlin, *supra*, and Boykin vs. Franklin Life Insurance Co., 14 Ga. App. 666, 82 S. E. 60, the judge of the superior court did not err in sustaining the certiorari and rendering final judgment in the case.

(For other cases, see *Insurance*, Cent. Dig. §§ 245, 404, 405; Dec. Dig. § 188[2].)

Error from Superior Court, De Kalb County; C. W. Smith, Judge. Action by J. T. Tucker against C. G. Chewning. Judgment for plaintiff, and defendant brings error. Affirmed.

Paul L. Lindsay, of Atlanta, for Plaintiff in Error.

B. H. Sullivan and Thos. J. Lewis, both of Atlanta, for Defendant in Error.

* Decision rendered, April 17, 1916. 88 S. E. Rep. 593. Syllabus by the Court.

**BROWN vs. MODERN WOODMEN OF AMERICA ET AL.**

(No. 20044.)*

(Supreme Court of Kansas.)

1. INSURANCE—CLAIMANTS UNDER FRATERNAL BENEFIT CERTIFICATE—EQUITY.

Generally the rights of holders and beneficiaries under fraternal benefit certificates rest solely upon the contract between the member and the association as found in its constitution and by-laws. But, when potent and manifest equities appear in favor of some of the rival claimants by reason of contracts made and carried out with the deceased member, the association raising no objection, the contest may become one purely for equitable cognizance and determination.

(For other cases, see *Insurance*, Cent. Dig. §§ 1967-1972, 1980; Dec. Dig. § 793.)

2. INSURANCE—FRATERNAL BENEFIT INSURANCE—CHANGE OF BENEFICIARIES—RIGHTS OF RIVAL CLAIMANTS.

While ordinarily the member has no vested right in the fund, still by an agreement to change beneficiaries in consideration of funds advanced

* Decision rendered, April 8, 1916. 156 Pac. Rep. 767. Syllabus by the Court.

he may so bind himself as to preclude his beneficiaries or heirs from asserting their claim to the proceeds against a party who advanced large sums on the strength of such agreement, although a completed change of beneficiary was not made in accordance with the constitution and by-laws of the association.

(For other cases, see Insurance, Cent. Dig. § 1954; Dec. Dig. § 784[7].)

Appeal from District Court, Riley County.

Action by Robert Henry Brown against the Modern Woodmen of America, a corporation, and others. From judgment for defendants, plaintiff appeals. Reversed and remanded.

John E. Hessin and John C. Hessin, both of Manhattan, for Appellant.

Dawes & Miller, of Clay Center, for Appellees.



LADIES' AUXILIARY OF ANCIENT ORDER OF HIBERNIANS OF MICHIGAN vs. FLANIGAN ET AL.

(No. 91.)*

(Supreme Court of Michigan.)

1. INSURANCE—MUTUAL BENEFIT INSURANCE—BENEFICIARIES.

Under a mutual benefit certificate stipulating that any member desiring any change in the certificate should apply to the secretary therefor, and that death benefits would be paid to the persons designated by the insured and otherwise to the personal representative of the insured, the insured's father or mother, designated as her beneficiaries, were entitled to the proceeds, notwithstanding the insured's marriage and the birth of a child which survived her and the payment of dues by her husband, where she had never designated any other beneficiary.

(For other cases, see Insurance, Cent. Dig. §§ 1967-1972, 1980; Dec. Dig. § 793.)

Appeal from Circuit Court, Kent County, in Chancery; Kelly S. Searl, Judge.

Interpleader by the Ladies' Auxiliary of the Ancient Order of Hibernians of the State of Michigan against Edward J. Flanigan and wife and George Holloway, administrator. Judgment for defendants Flanigan, and defendant Holloway, administrator, appeals. Affirmed.

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, Person, and Brooke, JJ.

Carroll, Kirwin & Hollway, of Grand Rapids, for Appellant.
James H Campbell, of Grand Rapids, for Appellees.

* Decision rendered, March 31, 1916. 157 N. W. Rep. 355.

ZENDER vs. DETROIT LODGE NO. 1 OF KNIGHTS OF ROYAL ARK ET AL. (No. 82.)*

(Supreme Court of Michigan.)

1. INSURANCE—VOLUNTARY ASSOCIATION—ASSESSMENT—VALIDITY.

Where the laws of defendant voluntary association made it the duty of the president to order assessments upon the death of members by notifying the financial secretary in writing of the assessment, and further provided for forfeiture of members' rights to death benefits for failure to pay assessments, a membership was not forfeited for failure to pay an assessment where not so ordered by the president; notice of the assessment being given by the financial secretary upon his own motion upon learning of a member's death.

(For other cases, see Insurance, Cent. Dig. § 1883; Dec. Dig. § 736.)

2. INSURANCE—VOLUNTARY ASSOCIATION—VALID ASSESSMENT—RATIFICATION.

Where at a meeting of the lodge subsequent to such action by the financial secretary the following entry was made in the minutes of the meeting: "W. O., Deceased. Death Benefit—Died May 26th. \$700.00"—such entry was not a ratification by the lodge of the action of the financial secretary in issuing notice of the assessment.

(For other cases, see Insurance, Cent. Dig. §§ 1898-1902; Dec. Dig. § 751[2].)

3. INSURANCE—VOLUNTARY ASSOCIATION—ASSESSMENT—TIME EXTENSION.

Where such notice of assessment was issued by the financial secretary on May 29th, and at a meeting on July 11th the lodge directed the secretary to mail notices of such assessment to each member, and the law of the order further provided that members not paying assessments within 30 days after notice forfeited mortuary benefits, tender of payment of such assessment on behalf of plaintiff's decedent on August 1st was in time to prevent a default, since the action of the lodge on July 11th constituted an extension of time in which such assessment could be paid.

(For other cases, see Insurance, Cent. Dig. § 1904; Dec. Dig. § 752.)

4. INSURANCE—FORFEITURE—POLICY—CONSTRUCTION.

Whenever it is possible by reasonable construction to prevent the forfeiture of an insurance policy and thereby preserve the equitable rights of the holder, it should be done.

(For other cases, see Insurance, Cent. Dig. § 1889; Dec. Dig. § 744.)

Error to Circuit Court, Wayne County; Henry A. Mandell, Judge.

Action by Carrie Zender against Detroit Lodge No. 1 of the Knights of the Royal Ark and another. From a directed verdict for plaintiff, defendants bring error. Affirmed.

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, Person, and Brooke, JJ.

* Decision rendered, March 31, 1916. 157 N. W. Rep. 361.

James A. Murtha and John H. Dohrman, both of Detroit, for Appellant.
Corliss, Leete & Moody and Benjamin S. Pagel, all of Detroit, for Appellee.

BRAUNSTEIN vs. FRATERNAL AID UNION.

(No. 19723 [19].)*

(Supreme Court of Minnesota)

1. INSURANCE—ACTION AGAINST FOREIGN CORPORATIONS—SERVICE ON INSURANCE COMMISSIONER.

Where a foreign insurance corporation has been duly authorized to do business in this state and has filed with the insurance commissioner the instrument appointing him and his successors its attorney upon whom process may be served as provided by statute so long as any liability remains outstanding in this state, the stipulation of the corporation in regard to the service of process becomes an obligation of the company precisely as though it were incorporated in the policies issued in this state to citizens thereof, and thereafter actions growing out of policies issued in this state may be commenced by service of the summons upon the insurance commissioner, as provided by statute, whether the corporation continues to do business in this state or not.

(For other cases, see Insurance, Cent. Dig. § 1573; Dec. Dig. § 627[2]; Corporations, Cent. Dig. §§ 2603-2627.)

2. INSURANCE—FOREIGN CORPORATIONS—ASSIGNEE—ASSUMPTION OF LIABILITIES—SERVICE OF PROCESS.

A foreign insurance corporation duly authorized to do business in this state went out of business and transferred its business and obligations to defendant, a foreign corporation which has never been authorized to do business in this state. Defendant assumed the liabilities of its assignors and predecessors. Held, that one of the liabilities assumed by defendant is the stipulation contained in the instrument theretofore filed by its assignors in the office of the insurance commissioner of this state, and that service of the summons upon the insurance commissioner in an action on an insurance contract made by its predecessor while doing business in this state subjects the defendant to the jurisdiction of the courts of this state.

(For other cases, see Insurance, Cent. Dig. § 1573; Dec. Dig. § 627[2]; Corporations, Cent. Dig. §§ 2603-2627.)

Appeal from District Court, Ramsey County; James C. Michael, Judge.

Action by Fannie D. Braunstein against the Fraternal Aid Union. From an order denying the motion to set aside service of summons, defendant appeals. Affirmed.

Wm. G. White, of St. Paul, for Appellant.

James E. Markham and A. J. Hertz (both of St. Paul), for Respondent.

* Decision rendered, May 5, 1916. 157 N. W. Rep. 721. Syllabus by the Court.

**BRUCK vs. JOHN HANCOCK MUT. LIFE INS. CO.
(No. 14354.)***

(St. Louis Court of Appeals. Missouri.)

1. INSURANCE—LIFE INSURANCE—ACTIONS—STATUTES.

Rev. St. 1909, § 6937, declaring that no misrepresentation made in obtaining a life policy shall be deemed material or render the policy void, unless the matter misrepresented shall have actually contributed to the contingency or event in which the policy is to become due and payable, and whether it so contributed in any case shall be a question for the jury, is not intended to prevent a court of equity from relieving against actual fraud.

(For other cases, see Insurance, Cent. Dig. §§ 1517-1519; Dec. Dig. § 608.)

2. INSURANCE—LIFE INSURANCE—MISREPRESENTATIONS.
Said statute applies alike to warranties and representations, and draws no distinctions between innocent and fraudulent misrepresentations.

(For other cases, see Insurance, Cent. Dig. § 684; Dec. Dig. § 291[2].)

5. INSURANCE—ACTIONS—LIFE INSURANCE.

Testimony of persons who have associated daily with the insured as to his state of health at the time of or prior to his application for insurance cannot be set aside as devoid wholly of evidentiary value.

(For other cases, see Insurance, Cent. Dig. §§ 1711-1716; Dec. Dig. § 665[3].)

Appeal from St. Louis Circuit Court; Leo S. Rassieur, Judge.
"To be officially published."

Action by Katie Bruck against the John Hancock Mutual Life Insurance Company. From a judgment for plaintiff, defendant appeals. Affirmed.

Leahy, Saunders & Barth, of St. Louis, for Appellant.
James J. O'Donohoe, of St. Louis, for Respondent.

* Decision rendered, May 2, 1916. On motion for rehearing, May 16, 1916. 185 S. W. Rep. 753.

**MADSDEN vs. PRUDENTIAL INS. CO. OF AMERICA.
(No. 14301.)***

(St. Louis Court of Appeals. Missouri.)

2. INSURANCE—LIFE INSURANCE—AGENTS.

As Rev. St. 1909, § 6938, declares that an agent soliciting insurance shall be deemed the agent of the insurer, the soliciting agent, after a life policy was written, who attempted to collect the premium, must in that matter be deemed the agent of the insurer.

(For other cases, see Insurance, Cent. Dig. §§ 948-951, 956-965; Dec. Dig. § 375[1].)

* Decision rendered, May 2, 1916. Rehearing denied, May 16, 1916. 185 S. W. Rep. 1168.

3. INSURANCE—LIFE INSURANCE—PROVISIONS OF POLICY.
Agents, who negotiate insurance, deliver policies, and collect premium installments, may, despite the provision in a life policy that its conditions could not be waived, save by an agent, either expressly or inferentially waive conditions of the policy.

(For other cases, see Insurance, Cent. Dig. §§ 952-954; Dec. Dig. § 376[1].)

4. INSURANCE—LIFE INSURANCE—WAIVER OF CONDITION.
Where a life company, with knowledge that a policy has lapsed, accepts a premium, it waives provisions regarding reinstatement, and, if desirous of insisting theron, should return the premiums.

(For other cases, see Insurance, Cent. Dig. §§ 1041, 1056; Dec. Dig. § 392[1].)

5. INSURANCE—LIFE INSURANCE—ACTIONS—EVIDENCE.

Whether a life company, which accepted a premium after a lapse of the policy, waived a condition that the insurer should make an application for reinstatement and furnish certificate of health, *held*, under the evidence, for the jury

(For other cases, see Insurance, Cent. Dig. §§ 1748, 1761, 1767, 1770; Dec. Dig. § 668[15].)

Appeal from St. Louis Circuit Court, Rhodes E. Cave, Judge.

"Not to be officially published."

Action by Walter H. Madsen, a minor, by Edna Madsen, his next friend, against the Prudential Insurance Company of America. From a judgment for defendant, plaintiff appeals. Reversed and remanded.

Hall & Dame, of St. Louis, for Appellant.

Fordyce, Holliday & White, of St. Louis, for Respondent.



WARD vs. BANKERS' LIFE CO. (WARD, Intervener.)

(No. 18917.)*

(Supreme Court of Nebraska.)

2. INSURANCE—ACTIONS ON POLICIES—PARTIES.

A trustee for the minor son of insured, when thus designated in a life insurance policy as beneficiary, is the proper party to maintain an action for unpaid insurance. Rev. St. 1913, §§ 7582, 7585.

(For other cases, see Insurance, Cent. Dig. §§ 1559, 1560; Dec. Dig. § 642[2].)

3. INSURANCE—ACTIONS ON POLICIES—COSTS—ATTORNEY'S FEE.

The statute, allowing plaintiff a reasonable sum as an attorney's fee in an action to recover insurance, is applicable to contracts executed before its enactment. Rev. St. 1913, § 3212.

(For other cases, see Insurance, Cent. Dig. §§ 1805, 1806; Dec. Dig. § 675.)

* Decision rendered, May 13, 1916. 157 N. W. Rep. 1017. Syllabus by the Court.

Appeal from District Court, Douglas County; Sutton, Judge.
Action by Harry R. Ward against the Bankers' Life Company, and Mary E. Ward intervenes. Reversed and remanded.

C. E. Herring, of Omaha, for Appellant.
I. M. Earle, of Des Moines, Iowa, I. N. Flickinger, of Council Bluffs, Iowa, and John H. Grossman, of Omaha, for Appellees.



SUPREME COUNCIL OF ROYAL ARCANUM vs. ALEXANDER ET AL. (No. 40/285.)*
(Court of Chancery of New Jersey.)

1. INSURANCE—FRATERNAL INSURANCE—CHANGE OF BENEFICIARY.

Evidence, in proceedings by rival claimants to the proceedings of an insurance certificate, held not to show that the member in changing the beneficiary made a false affidavit.

(For other cases, see Insurance, Cent. Dig. § 2006; Dec. Dig. § 819[1].)

3. INSURANCE—FRATERNAL INSURANCE—RIVAL CLAIMANTS—EVIDENCE.

Where a wife, who had been named beneficiary in a fraternal certificate, claimed the fund as against a subsequently named beneficiary, evidence held insufficient to show that she having received the certificate on faith thereof, made loans to her husband so as to be not entitled to priority over the last beneficiary.

(For other cases, see Insurance, Cent. Dig. § 2006; Dec. Dig. § 819[1].)

Bill of interpleader by the Supreme Council of the Royal Arcanum, a corporation, against Madeline Alexander and Sidney Alexander, rival claimants. Decree for latter.

W. Holt Apgar, of Trenton, for Complainant.
H. H. Voorhees, of Camden, for Defendant Madeline Alexander.
W. M. Seufert, of Englewood, for Defendant Sidney M. Alexander.

* Decision rendered, March 31, 1916. 97 Atl. Rep. 276.



BORN ET AL. vs. PERKINS.*
(Supreme Court of New York, Appellate Division, Third Department.)

INSURANCE—FRATERNAL BENEFICIARY INSURANCE—ACTION FOR BENEFITS—LIMITATION.

Under the insurance benefit provisions of a cigar makers' union, that on becoming a member of the union each member should designate the person to whom the death benefits should be paid, and that if he made no designation by will, and no claim to such benefits was made by any

* Decision rendered, May 3, 1916. 158 N. Y. Supp. 673.

such person or his heirs, or representatives within one year after the death of the member, all claims should lapse and the benefits should revert to the union, a claim by a member's heirs, not made until four years after his death, and after the benefits had reverted to the union, was barred, notwithstanding the heirs did not sooner learn of his death.

(For other cases, see Insurance, Cent. Dig. § 1993; Dec. Dig. § 812.)

Action by Wallac Born and another, as sole heirs at law of James Born, deceased, against G. W. Perkins, as president of the Cigarmakers' International Union of America. Exceptions by the plaintiff upon the trial at the Trial Term were directed to be heard in the first instance by the Appellate Division, pursuant to an order of Mr. Justice Hasbrouck, dated January 5, 1916, in Albany County. Exceptions overruled, and complaint dismissed.

Argued before Kellogg, P. J., and Lyon, Howard, Woodward, and Cochrane, JJ.

William Goldberg, of Albany (Louis J. Rezzemini, of Albany, of counsel), for Plaintiffs.

Mills & Mills, of Albany (Borden H. Mills, of Albany, of counsel), for Defendant.



PARRISH *vs.* AMERICAN NAT. INS. CO. (No. 253.)*

(Supreme Court of North Carolina.)

3. INSURANCE—ACTIONS ON POLICIES—ISSUES.

In an action on a life insurance policy, where the pleadings, evidence, and issue tendered by defendant showed that the only representation in the application relied on to defeat the policy was that applicant did not have cancer of the womb, it was not error for the court to confine the representations to those concerning cancer of the womb.

(For other cases, see Insurance, Cent. Dig. §§ 1554, 1632; Dec. Dig. § 654[1].)

Appeal from Superior Court, Franklin County; Peebles, Judge.

Action by W. A. Parrish against the American National Insurance Company. Judgment for plaintiff, and defendant appeals. No error.

Ben T. Holden and Wm. H. Ruffin, both of Louisburg, for Appellant.
W. M. Person and Bickett, White & Malone, all of Louisburg, for Appellee.

* Decision rendered, April 12, 1916. 88 S. E. Rep. 500.

**SOVEREIGN CAMP OF WOODMEN OF THE WORLD
vs. JACKSON. (No. 5131.)***

(Supreme Court of Oklahoma.)

1. INSURANCE—FRATERNAL BENEFIT INSURANCE—INITIATION OF APPLICANT.

When deceased has been accepted for membership by the local camp and his application for insurance has been accepted by the head camp, and benefit certificate issued, and same has been delivered to the member and his dues collected thereon, the lodge is estopped to deny that he is a member, and will not be heard to object that he has not been initiated.

(For other cases, see Insurance, Cent. Dig. §§ 1837, 1866, 1868; Dec. Dig. § 724[1].)

2. INSURANCE—FRATERNAL BENEFIT INSURANCE—CONTRACT—"GOOD HEALTH."

The phrase "in good health" is a comparative term, and the fact that deceased was suffering with a slight cold at the time the benefit certificate was delivered to him, which afterwards developed into pneumonia and caused his death, will not defeat a recovery upon the benefit certificate under the stipulation that the insured be "in good health" when the policy is delivered to him.

(For other cases, see Insurance, Cent. Dig. § 1863; Dec. Dig. § 723[5].)

(For other definitions, see Words and Phrases, First and Second Series, Good Health.)

On Rehearing.

3. INSURANCE—FRATERNAL BENEFIT INSURANCE—EXTENT OF LIABILITY.

A beneficiary certificate issued by the order of the Woodmen of the World contained a clause that the order would pay the sum of \$100 for the erection of a monument to the memory of the member to whom the certificate was issued. *Held*, in default in the erection of said monument, the beneficiary named in the policy or certificate was not entitled to a personal judgment for the said \$100.

(For other cases, see Insurance, Cent. Dig. § 2012; Dec. Dig. § 828.)

Commissioners' Opinion, Division No. 4. Error from District Court, Bryan County; Jesse M. Hatchett, Judge.

Action by Mrs. Daisy Jackson against the Sovereign Camp of Woodmen of the World. Judgment for plaintiff, and defendant brings error. Modified and affirmed.

Maxey, Jackson & Dial, of Muskogee, for Plaintiff in Error.
Utterback, Hayes & MacDonald, of Durant, for Defendant in Error.

* Decision rendered, April 18, 1916. 157 Pac. Rep. 92. Syllabus by the Court.

EDINGTON vs. MICHIGAN MUT. LIFE INS. CO.*
(Supreme Court of Tennessee.)

2. INSURANCE—DECREE PRO CONFESSO—PLEADING DATE OF INCEPTION.

In suit on a life policy, under a bill alleging that on September 18, 1905, insured applied for the policy, that it was not issued before the 22d, and that complainants could not state the exact date, as insured had borrowed on the policy and it was in possession of the insurer, September 22d must be treated as the date of the inception of the insurance.

(For other cases, see Insurance, Cent. Dig. §§ 1575-1580, 1584-1586, 1592, 1598; Dec. Dig. § 629.)

3. INSURANCE—LIFE INSURANCE—LAPSING OF POLICY.

Where insured, under a life policy issued September 22, 1905, paid premiums for nine full years in advance, including the year 1913, which carried the policy to noon of September 22, 1914, and such insured died on the early morning of that day, the policy had not lapsed at the time of his death.

(For other cases, see Insurance, Cent. Dig. §§ 372-378; Dec. Dig. § 177.)

5. INSURANCE—LIFE INSURANCE—REINSTATEMENT—PROVISION FOR GRACE IN PAYMENT OF PREMIUMS.

The provision for grace, secured to the insured by Acts 1907, c. 457, § 2, providing that no policy of life insurance shall be issued, unless containing a provision for a grace of one month for the payment of every premium after the first year, became a part of the policy itself upon reinstatement, subsequent to the taking effect of the act, after lapsing for failure to pay premiums.

(For other cases, see Insurance, Cent. Dig. § 932; Dec. Dig. § 365[1].)

6. INSURANCE—FAILURE TO PAY PREMIUM—EFFECT.

Ordinarily, where a contract of insurance provides that it shall be void if the premiums are not paid when due, or within a specified time, default in payment of a premium when due will determine the insurance without any action by the insurer, and the policy cannot be revived without a new contract.

(For other cases, see Insurance, Cent. Dig. §§ 891, 895, 896, 899-902; Dec. Dig. § 349[1].)

Error to Chancery Court, Hamilton County; W. B. Garvin, Chancellor. Suit by Mrs. Etta S. Edington, Administratrix, against the Michigan Mutual Life Insurance Company. To review a judgment for plaintiff, defendant brings error. Affirmed.

Littleton, Littleton & Littleton, of Chattanooga, for Plaintiff in Error. W. E. Wilkerson, W. B. Miller, and W. L. Frierson, all of Chattanooga, for Defendant in Error.

* Decision rendered, Nov. 16, 1915. 183 S. W. 728.

AMERICAN NAT. INS. CO. *vs.* VAN DUSEN. (No. 6487.)*

(Court of Civil Appeals of Texas. Galveston.)

3. INSURANCE—AGENTS—CONTRACT OF EMPLOYMENT—INTENTION OF PARTIES—SUFFICIENCY OF EVIDENCE.

In suit by its superintendent of agents against an insurance company for breach of his contract of employment, evidence held to show that the parties intended and understood that the superintendent's employment was for five years, subject to a stipulation as to increase in revenues, and that the company was not to have the right to discharge him at pleasure.

(For other cases, see Insurance, Cent. Dig. § 101; Dec. Dig. § 76.)

4. INSURANCE—AGENTS—CONTRACT OF EMPLOYMENT—RIGHT OF DISCHARGE.

Where the superintendent of agents of an insurance company violated his contract of employment in any particular, or was unfaithful in the discharge of his duties, the company could treat the contract as no longer binding, and dismiss the superintendent, though the contract provided that it should run for five years, provided the superintendent made a stipulated increase in business and collections.

(For other cases, see Insurance, Cent. Dig. § 104; Dec. Dig. § 79.)

5. INSURANCE—AGENTS—CONTRACT OF EMPLOYMENT—CONSTRUCTION.

The contract of employment of a superintendent of agents for an insurance company, which, after providing that the contract should run for five years, if the superintendent make a stipulated increase in business and collections, provided the compensation to which he would be entitled if the contract were terminated by "dismissal," referred, by the use of the word, to dismissal for causes besides a breach of the stipulation as to increase in business.

(For other cases, see Insurance, Cent. Dig. § 104; Dec. Dig. § 79.)

6. INSURANCE—CONTRACT OF EMPLOYMENT—AMBIGUITY—QUESTION FOR COURT.

In suit by its superintendent of agents against an insurance company for breach of his contract of employment, it was the province of the court to determine whether the contract was ambiguous in relation to the right to discharge.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

8. INSURANCE—AGENTS—ACTION FOR WRONGFUL DISCHARGE—PLEADING.

In an action by its superintendent of agents against an insurance company for breach of his contract of employment, it was not necessary that plaintiff's petition should allege what effort he made to reduce the damages caused him by his discharge by obtaining other employment, and what amount he earned or might have earned by reasonable diligence in such other employment.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

* Decision rendered, Dec. 17, 1913. Certified questions withdrawn and rehearing denied, April 27, 1916. 185 S. W. Rep. 634.

9. INSURANCE—AGENTS—ACTION FOR WRONGFUL DISCHARGE—EVIDENCE—EARNINGS.

In suit by its superintendent of agents against an insurance company for wrongful discharge, testimony of plaintiff as to the amount he would have made under the contract of employment, based on his statements as to what his earnings were before discharge, and the conditions existing in reference to the business after discharge, was admissible.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)
McMeans, J., dissenting.

Appeal from District Court, Harris County; Norman G. Kittrell, Judge.

Suit by J. P. Van Dusen against the American National Insurance Company. From a judgment for plaintiff, defendant appeals. Affirmed.

Lane, Wolters & Storey, of Houston, and Williams & Neethe, of Galveston, for Appellant.

Clark & Kapner and Bryan & Bryan, all of Houston, for Appellee.



PRUDENTIAL LIFE INS. CO. OF TEXAS vs. SMYER ET AL.

(No. 879.)*

(Court of Civil Appeals of Texas. Amarillo.)

1. INSURANCE—ISSUANCE OF STOCK FOR NOTE—CONSTITUTION.

The issuance of stock by an insurance company in return for a note and a deed of trust and the note so given were void, being in violation of Const. art. 12, § 6, providing that no corporation shall issue stock except for money paid, labor done, or property actually received, although a third person subsequently sold property to the corporation, taking the note in part payment.

(For other cases, see Insurance, Cent. Dig. § 38; Dec. Dig. § 33.)

2. INSURANCE — INSURANCE COMPANIES — ISSUANCE OF STOCK FOR NOTE—STATUTE.

The issuance of stock by an insurance company for a note secured by deed of trust, and the note itself, were void, as in violation of Vernon's Sayles' Ann. Civ. St. 1914, arts. 4725, 4726, 4728, touching the organization of insurance companies, and providing that the amount of an insurance company's capital stock must be subscribed and fully paid up and in the hands of the incorporators before articles of incorporation are filed, etc.

(For other cases, see Insurance, Cent. Dig. § 38; Dec. Dig. § 33.)

Appeal from District Court, Swisher County; R. C. Joiner, Judge.

Action by J. F. Smyer against the Prudential Life Insurance Company of Texas and Nat M. Washer. From a judgment sustaining demurrer to

* Decision rendered, Jan. 5, 1916. On motion for rehearing, Feb. 9, 1916.
183 S. W. Rep. 825.

the Insurance Company's answer, it appeals. Affirmed in part, reversed in part, and judgment rendered.

Jas. A. King, of Albany, for Appellant.

Y. W. Holmes, of Plainview, for Appellee Smyer.

Ball & Seeligson and C. W. Truehart, all of San Antonio, for Appellee Washer.

ROYAL NEIGHBORS OF AMERICA *vs.* HEARD ET AL.
(No. 5608.)*

(Court of Civil Appeals of Texas. Austin.)

INSURANCE—ACTIONS ON POLICIES—PLEADING.

Under Rev. St. 1911, art. 7093, providing that written instruments shall import a consideration in the same manner as sealed instruments under the common law, and article 1906, providing that the consideration of a written instrument cannot be impeached or put in issue except by sworn pleadings, in an action against a beneficiary association on a written policy, it was not necessary for the plaintiffs to allege in their pleadings that the written contract sued upon was based upon a sufficient consideration.

(For other cases, see *Insurance*, Cent. Dig. § 1998; Dec. Dig. § 815[4].)

Error from District Court, Tom Green County; J. W. Timmins, Judge.

Suit by Mrs. Cora Heard and another against the Royal Neighbors of America. Judgment for the plaintiffs, and defendant brings error. Affirmed.

Davis, Johnson & Golden, of Dallas, for Plaintiff in Error.

W. A. Anderson and W. E. Taylor, both of San Angelo, for Defendants in Error.

* Decision rendered, March 22, 1916. Rehearing denied, April 19, 1916. 185 S. W. Rep. 882.

FEDERAL LIFE INS. CO. *vs.* HOSKINS. (No. 7429.)

(Court of Civil Appeals of Texas. Dallas.)

1. INSURANCE—FRAUD—ESTOPPEL.

Where the insured is induced to sign an application by false representations of the agent that it provides for such policy as they have agreed upon, when, in fact, it provides for another and materially different policy, he is not estopped from setting up such false representations, unless inexcusably negligent in not informing himself, though he could have done so by reading the application when he signed it.

(For other cases, see *Insurance*, Cent. Dig. § 262; Dec. Dig. § 141[4].)

* Decision rendered, April 1, 1916. Rehearing denied, April 29, 1916. 185 S. W. Rep. 607.

2. INSURANCE—FRAUD—QUESTION FOR JURY.

Whether insured, giving his note for and accepting a policy covering a different period than that alleged to have been represented by the insurer's agent, was inexcusably negligent, was a question of fact for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 465-467; Dec. Dig. § 198[6].)

Appeal from Dallas County Court; T. A. Work, Judge.

Action by John T. Hoskins against the Federal Life Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Lawther, Pope & Mays, of Dallas, for Appellant.

George, Hancock & Hardwicke, of Dallas, for Appellee.

**LAWSON vs. UNITED BENEV. ASS'N. (No. 8358.)***

(Court of Civil Appeals of Texas. Ft. Worth.)

1. INSURANCE—MUTUAL BENEFIT ASSOCIATION—BENEFICIARY—CONSTITUTION AND BY-LAWS.

Under a mutual benefit association, policy designating one as beneficiary by name, followed by the words, "bearing relationship of husband," and expressly subject to the constitution and laws of the association, which limits beneficiaries to husband or wife or certain relatives, a divorced husband cannot take as beneficiary, although the designation has not been changed by the wife in her will.

(For other cases, see Insurance, Cent. Dig. §§ 1935, 1937; Dec. Dig. § 771.)

2. INSURANCE—INSURABLE INTEREST—HUSBAND.

A divorced husband has no insurable interest in the life of his former wife.

(For other cases, see Insurance, Cent. Dig. §§ 1929-1931; Dec. Dig. 767.)

3. INSURANCE—MUTUAL BENEFIT ASSOCIATIONS—CHANGE OF BENEFICIARY.

Where a mutual benefit policy, limiting beneficiaries to husband and wife and relatives, was payable to a husband, who was later divorced, no right to recover on the policy was given him by the will of his former wife in his favor.

(For other cases, see Insurance, Cent. Dig. § 1941; Dec. Dig. § 775.)

4. INSURANCE—MUTUAL BENEFIT ASSOCIATIONS—CHANGE OF BENEFICIARY—ESTOPPEL.

An association is not estopped to deny the rights of a divorced husband as beneficiary on his wife's policy by accepting premiums thereon from him after divorce, or that it paid him, after her death, a funeral benefit, for the payment of premiums may be presumed to have been

* Decision rendered, April 8, 1916. Rehearing denied, May 6, 1916. 185 S. W. Rep. 976.

for the benefit of surviving children and the funeral benefit to have been used for funeral expenses.

(For other cases, see Insurance, Cent. Dig. §§ 1909-1913, 1915, 1916; Dec. Dig. § 755[3].)

5. INSURANCE—MUTUAL BENEFIT ASSOCIATIONS—INSURANCE PREMIUMS—VOLUNTARY PAYMENTS.

Voluntary payments of premiums by one not a beneficiary of a policy cannot be recovered.

(For other cases, see Insurance, Cent. Dig. § 1888; Dec. Dig. § 743.)

Appeal from District Court, Tarrant County; J. W. Swayne, Judge. Action by James W. Lawson against the United Benevolent Association. From a judgment for defendant, plaintiff appeals. Affirmed.

Lattimore, Cummings, Doyle & Bouldin, of Ft. Worth, for Appellant. Morris Rector, of Ft. Worth, for Appellee.



SAN ANTONIO LIFE INS. CO. vs. GRIFFITH. (No. 8327.)*

(Court of Civil Appeals of Texas. Ft. Worth.)

6. INSURANCE—AGENTS—BREACH OF CONTRACT BY PRINCIPAL—DAMAGES—EVIDENCE.

In an action by a life insurance company, evidence *held* sufficient to sustain the court's finding as to the amount of recovery for time lost by the company's failure to make advances as agreed, which prevented the agent from prosecuting his work.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

7. INSURANCE—AGENTS—BREACH OF CONTRACT BY PRINCIPAL—DAMAGES—EVIDENCE.

In an action by a life insurance agent for breach of the company's promise to make advances, testimony that the agent's business was increased, and that he had quite a few prospects worked up, justified the court in concluding that his commissions would have been more than at the beginning of his agency.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

8. INSURANCE—AGENTS—BREACH OF CONTRACT BY PRINCIPAL—BURDEN OF PROOF.

In an action for breach of an insurance company's contract to make advances to its agent, which prevented his working, the burden of proving that he could have gotten advances from some other source to prosecute his work, or could have found employment in some other business, and thereby avoided or reduced his damages, is on the defendant.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

* Decision rendered, March 4, 1916. Rehearing denied, April 8, 1916. 185 S. W. Rep. 335.

9. INSURANCE—AGENTS—BREACH OF CONTRACT BY PRINCIPAL—ISSUES.

In an action by a life insurance agent for special damages for the company's breach of its contract to advance to the agent, as funds with which to continue his work, the amount of his commission in premium notes taken by him, he cannot recover for the balance of commissions included in notes not paid, since the need of the funds ceased when the agent accepted the breach as terminating his contract and sued for damages.

(For other cases, see Insurance, Cent. Dig. § 111; Dec. Dig. § 84[2].)

10. INSURANCE—AGENTS—BREACH OF CONTRACT OF PRINCIPAL—DAMAGES.

In an action for breach of an insurance company's contract to make advances to the agent to enable him to continue work, plaintiff could not recover for the loss of the business, given up by him to accept employment with the insurance company.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

Appeal from District Court, Wichita County; E. W. Nicholson, Judge.

Action by W. L. Griffith against the San Antonio Life Insurance Company. Judgment for plaintiff for part of the amount sued for, and defendant appeals, and plaintiff files a cross-appeal. Modified by reducing the amount, and affirmed.

John F. Onion, of San Antonio, and Carrigan, Montgomery & Britain, of Wichita Falls, for Appellant.

Chauncey & Davenport, of Wichita Falls, for Appellee.



FIRST TEXAS STATE INS. CO. vs. CAPERS. (No. 7075.)*

(Court of Civil Appeals of Texas. Galveston.)

1. INSURANCE—LIFE POLICY—FORFEITURE—WAIVER.

Forfeiture of a life policy for failure to seasonably pay a premium, and provisions for manner of reinstatement, are waived by a receipt and retention of the past-due premium by insurer's agent, duly authorized to receive it, with knowledge that it had not been paid in time.

(For other cases, see Insurance, Cent. Dig. §§ 1041-1056, 1058-1070; Dec. Dig. § 392.)

Appeal from Harris County Court; C. C. Wren, Judge.

Action by John B. Capers against the First Texas State Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Baker, Botts, Parker & Garwood and W. A. Parish, all of Houston, for Appellant.

Atkinson, Graham & Atkinson and Heidingsfelders, all of Houston, for Appellee.

* Decision rendered, Feb. 12, 1916. Rehearing denied, March 2, 1916. 183 S. W. Rep. 794.

FIRST TEXAS STATE INS CO. vs. BELL. (No. 1565.)*

(Court of Civil Appeals of Texas. Texarkana.)

1. INSURANCE — LIFE INSURANCE — DEFERRED RISK — STATUTE.

Under Rev. Civ. St. art. 4742, subd. 3, declaring that no policy of life insurance shall be issued providing for any mode of settlement at maturity of less value than the amounts insured on the face of the policy, plus dividends, and less any indebtedness on the policy, etc., a stipulation in a policy, that if insured should die from heart disease within one year from its date the insurer's liability would be limited to one-fourth of the principal sum named, was unenforceable and presented no defense to a claim for the full amount of the policy. (For other cases, see Insurance, Cent. Dig. §§ 1300-1302; Dec. Dig. § 515.)

Appeal from Harrison County Court; Geo. L. Huffman, Judge. Action by Sam Bell against First Texas State Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Bibb & Bibb, of Marshall, for Appellant.

Cary M. Abney and M. M. O'Banion, both of Marshall, for Appellee.

* Decision rendered, Feb. 23, 1916. Rehearing denied, March 9, 1916. 184 S. W. Rep. 277.

**CHRISTMAN vs. CHRISTMAN ET AL.***

(Supreme Court of Wisconsin.)

1. INSURANCE—LIFE INSURANCE—CHANGE OF BENEFICIARY —MARRIED WOMEN—STATUTE.

Since under St. 1915, § 2347, providing that where an insurance policy is expressed to be for the benefit of a married woman, it shall be her separate property, where the insured made his wife the beneficiary of an insurance policy, reserving the right to change the beneficiary at any time by written notice to the company, she took a vested interest in the policy, subject to be divested only in the manner reserved in the policy, a provision in his will, bequeathing the proceeds of the policy to others, did not operate a change of beneficiary.

(For other cases, see Insurance, Cent. Dig. § 1469; Dec. Dig. § 587.)

2. INSURANCE — LIFE INSURANCE — MARRIED WOMEN — CHANGE OF BENEFICIARY.

Since the wife took a vested interest in the policy, although her status as a married woman was changed by divorce, the policy would still belong to her, because her interest therein had not been effectually divested.

(For other cases, see Insurance, Cent. Dig. § 1470; Dec. Dig. § 586.)

* Decision rendered, May 23, 1916. 157 N. W. Rep. 1099.

Appeal from Circuit Court, Rock County; George Grimm, Judge.

Action by Emily M. Christman against Harrison E. Christman, as executor of Farmer W. Christman, and others. Judgment for plaintiff, and defendants appeal. Affirmed.

Charles E. Pierce, of Janesville, for Appellants.

Thomas S. Nolan, of Janesville, for Respondent.



**NATIONAL LIFE INS. CO. OF UNITED STATES ET AL. VS.
BRAUTIGAM ET AL.***

(Supreme Court of Wisconsin.)

**INSURANCE—LIFE INSURANCE—CHANGE OF BENEFICIARY—
MARRIED WOMEN—STATUTE.**

St. 1915, § 2347, preventing the divesting of the rights of a married woman beneficiary under a life insurance policy without her consent, applies only to cases where no reservation of the right to change the beneficiary is made or provided for in the policy, operating in all cases where no reservation of right to change the beneficiary is made or provided for, but permitting the insured, where the right to change the beneficiary is reserved, to change the beneficiary, though a married woman, in conformity with the terms of the reservation.

(For other cases, see Insurance, Cent. Dig. § 1469; Dec. Dig. § 587.)

Appeal from Circuit Court, Milwaukee County; Lawrence W. Halsey, Judge.

On rehearing. Former judgment vacated, judgment below reversed, and cause remanded, with directions.

For former opinion, see 154 N. W. 839.

J. O. Carbys, of Milwaukee (Miller, Mack & Fairchild, of Milwaukee, of counsel), for Appellants.

Joseph R. Dyer, of Milwaukee (Olin, Butler, Stebbins & Stroud, of Madison, of counsel), for Northwestern Mut. Life Ins. Co.

Rubin, Fawcett & Dutcher, of Milwaukee (Paul R. Newcomb, of Milwaukee, of counsel), for Respondent.

* Decision rendered, May 2, 1916. 157 N. W. Rep. 782.

ORMOND VS. MCKINLEY.*

(Supreme Court of Wisconsin.)

**INSURANCE—FRATERNAL BENEFIT INSURANCE—CHANGE
IN BENEFICIARY—STATUTE.**

Under St. 1898, § 1955c, intended to apply to all mutual benefit and fraternal societies by omitting the limitation of the prior statute confining its application to those organized in Wisconsin, and providing that

* Decision rendered, May 2, 1916. 157 N. W. Rep. 786.

any member of such a society may name as his beneficiary any person having an insurable interest in his life, and may change the beneficiary named in his certificate or policy without the consent of such beneficiary, a member of a fraternal benefit society whose certificate named his then wife as beneficiary, could, after divorce, by complying with the rules of his order, change the certificate to make his second wife the beneficiary, entitling her to the benefit on his death, the provisions of the statute being part of the terms of the certificate, and all persons acquiring any interest therein receiving it subject to the conditions imposed.

(For other cases, see *Insurance, Cent. Dig.* § 1946; *Dec. Dig.* § 780.)

Appeal from Circuit Court, Manitowoc County; Michael Kirwan, Judge.

Action by Laura Ormond against Nellie McKinley. From an order sustaining demurrers to the answer and cross-complaint, defendant appeals. Affirmed.

Otjen & Otjen, of Milwaukee, for Appellant.
Hougen & Brady, of Manitowoc, for Respondent.

FIRE, TORNADO, ETC.**COURT OF APPEALS OF KENTUCKY.**

NIAGARA FIRE INS. CO.

v/c

LAYNE.*

1. INSURANCE—AVOIDANCE OF POLICY—INCUMBRANCES.

Where insurer makes no inquiry, failure of insured to disclose the existence of a mortgage will not avoid the policy, unless the insured knew of the incumbrance, and it was such that an ordinarily prudent person would know it to be material to the risk.

(For other cases, see Insurance, Cent. Dig. §§ 613, 614; Dec. Dig. § 282[6].)

2 INSURANCE—AVOIDANCE OF POLICY—FRAUD.

To avoid a policy there must be a fraudulent concealment of a material fact.

(For other cases, see Insurance, Cent. Dig. §§ 538-542; Dec. Dig. § 253.)

3. INSURANCE—ACTIONS ON POLICIES—AMOUNT OF RECOVERY.

Evidence examined, and held to show that the loss of the insured was substantially less than the verdict.

(For other cases, see Insurance, Cent. Dig. § 1722; Dec. Dig. § 665[4].)

Appeal from Circuit Court, Pike County.

Action by Marion Layne against the Niagara Fire Insurance Company. Judgment for plaintiff, and defendant appeals. Reversed and remanded.

See, also, 162 Ky. 665, 172 S. W. 1090.

Hager & Stewart, of Ashland, and James Sowards, of Pikeville, for Appellant.

J. J. Moore, of Pikeville, for Appellee.

CARROLL, J.

This is the second appeal of this case by the insurance company. The opinion on the former appeal may be found in 162 Ky. 665, 172 S. W. 1090. On the former appeal the question involved was whether the liability of the appellant insurance company on a policy issued on a stock of merchandise encumbered by a mortgage could be avoided on the ground that the company, at the time it issued the insurance, had no notice of the mortgage. In considering and disposing of this question the court, after referring to a number of authorities, said:—

“From these authorities, it will be seen that the rule in this

* Decision rendered, May 23, 1916. 185 S. W. Rep. 1136.

state is that if no inquiry is made and answered concerning incumbrances, and no voluntary statement is made by the insured in regard thereto, the failure to disclose the existence of incumbrances on the property sought to be insured will not be ground for an avoidance of the policy, unless (1) the insured fraudulently failed to make such disclosure, and (2) unless the incumbrance was material to the risk assumed by the company.

"Such failure to disclose the existence of a lien material to the risk is fraudulent when the insured has knowledge of the incumbrance, and the facts are such that an ordinarily prudent person would have known that the existence of the incumbrance was material to the risk.

"An incumbrance is material to the risk when, with a knowledge of the truth, an insurer acting in accordance with the usual practice or custom among insurance companies would not have issued the policy."

And further said:—

"In the case at bar, Layne bought the stock of merchandise from Collingsworth at the price of \$2,050, giving him a mortgage thereon and also on a tract of land, to secure the sum of \$1,833. And the materiality of this incumbrance is a matter to go to the jury upon proper evidence of the usage and custom of insurance companies."

In discussing the instructions that should be given on a retrial of the case the court laid down the following principles for the guidance of the trial court:—

"If no inquiry concerning incumbrances has been made and answered and no voluntary statement in respect thereto has been made by the insured, section 639, Kentucky Statutes, is not applicable; where the applicant for insurance does answer inquiries or make voluntary statements, section 639 controls, and if the fact be material and the answer or statement untrue, the policy is avoided whether the applicant knew the statement to be untrue or not, and regardless of any intent to mislead or deceive the insurer (in the absence of estopping knowledge upon the part of the agent); but where no inquiry is made and answered concerning incumbrances, and no voluntary statement in regard thereto is made by the applicant for insurance, an avoidance of the policy will not be declared unless the insured fraudulently failed to disclose the incumbrance and it was material to the risk; failure to disclose the existence of an incumbrance material to the risk is fraudulent when the insured has knowledge of the incumbrance, and the facts are such that an ordinarily prudent person would have known that the existence of the incumbrance, or other fact, is material to the risk when with a knowledge of the truth, an insurer acting according to the usual practice or custom among insurance companies would not have issued the policy. * * *"

On the second trial of the case the evidence was substantially

the same as on the first trial. It was further undisputed that Layne purchased the stock of goods from a man named Collingsworth who had a policy of insurance in the appellant insurance company on the stock of goods, and that when the sale was made Collingsworth, with the consent of the company, transferred the insurance to Layne. It was further undisputed that Collingsworth took from Layne a mortgage on the stock of merchandise to secure the purchase price, and that the company did not know of the existence of the mortgage at the time the transfer of the insurance policy to Layne was made. It was also undisputed that the company did not make any inquiry concerning the existence of a mortgage or incumbrance on the merchandise, nor did either Layne or Collingsworth make any statement to the company in relation to the mortgage or any incumbrance.

With the evidence in this condition, the court instructed the jury as follows:—

"No. 2. The court instructs the jury that failure to disclose the existence of a lien material to the risk is fraudulent when the insured has knowledge of the incumbrance and the facts are such that an ordinarily prudent person would have known that the existence of the incumbrance was material to the risk; and that an incumbrance is material to the risk when, with knowledge of its existence, an insurer, acting in accordance with the usual practice and custom among insurance companies, would not have issued the policy.

"If the jury believe from the evidence that at the time of giving consent to transfer of the policy in suit the agent of the company did not know of the existence of the mortgage upon the stock of goods, and that the existence thereof was material to the risk as above herein defined, and that the agent would not have consented to transfer of the policy, if he had known that the stock of merchandise was encumbered with the mortgage; and if the jury further believe from the evidence that Mose Collingsworth concealed from the agent of the defendant company the existence of said mortgage, and that said concealment was fraudulent, then the jury will find for defendant."

The objection urged to this instruction by counsel for the insurance company refers to that part of it reading:—

"And if the jury further believe from the evidence that Mose Collingsworth concealed from the agent of the defendant company the existence of said mortgage, and that said concealment was fraudulent, then the jury will find for defendant."

The argument is that the jury should have been instructed that if the existence of the mortgage was concealed, the policy was avoided, although the concealment was not fraudulent. The part of the instruction objected to must of course be read in connection with the beginning of the instruction, which advised the jury that:—

"Failure to disclose the existence of a lien material to the risk

is fraudulent when the insured has knowledge of the incumbrance, and the facts are such that an ordinarily prudent person would have known that the existence of the incumbrance was material to the risk."

When so read the instruction, taken as a whole, follows the direction given by the court in the opinion. It was there said that the failure of the insured to advise the insurance company of the existence of an incumbrance on the property sought to be insured would not avoid the policy, unless:—

"(1) The insured fraudulently failed to make such disclosure; and (2) unless the incumbrance was material to the risk assumed by the company."

And that:—

"The failure to disclose the existence of an incumbrance material to the risk is fraudulent when the insured has knowledge of the incumbrance, and the facts are such that an ordinarily prudent person would have known that the existence of the incumbrance was material to the risk."

[1] So that the rule laid down in the opinion, and now reaffirmed is that the existence of a mortgage will not avoid the policy when no inquiry is made by the company and no statement is made by the insured, unless the insured has knowledge of the incumbrance, and it further appears that an ordinarily prudent person would have known that the existence of the incumbrance was material to the risk. When the insured has this character of knowledge, then his concealment of the existence of the incumbrance from the insurance company, or his failure to inform the insurance company of its existence, is fraudulent and will avoid the risk if the incumbrance was material to the risk and the company, according to the usual practice or custom of insurance companies, would not have issued the policy if it had known of the incumbrance.

If an ordinarily prudent person would not have known that the existence of the incumbrance was material to the risk or if its existence was not in fact material to the risk, the failure to inform the company of the incumbrance will not be fraudulent, nor will the concealment of the incumbrance avoid the policy. An insurance company knows exactly the conditions in its policy and on what character of property it will take insurance, and what character of incumbrance or other defect in the title will cause it to decline the insurance, and it should make inquiry of the insured of any fact it deems material to the risk and put him on notice as to conditions it desires information concerning. And when it issues the insurance without making any inquiry of the insured concerning incumbrances or other defects in the title, it will not be heard to say that the existence of the incumbrance or defect avoided the policy, unless the insured knew of the incumbrance or defect in the title, and they were in fact material to the

risk; and it further appears that a person of ordinary prudence would have known that they were material to the risk, and with this knowledge he concealed their existence from the company.

[2] It must further appear that the fact concealed was material to the risk, because to avoid the policy there must be the fraudulent concealment of a material fact. The two things must concur.

The next ground urged for reversal is that the verdict is flagrantly excessive. There were two insurance policies of equal amounts on the merchandise destroyed by the fire; one of these policies being held by the appellant insurance company, and consequently it was liable for one-half of three-fourths of the loss; the other company being liable for the other one-half. On the first trial the jury fixed the value of the goods destroyed at \$1,100, and found a verdict against the appellant insurance company for one-half of that amount, \$550. On the second trial the jury fixed the value of the goods at \$1,600 and returned a verdict against the appellant insurance company for \$800.

The evidence as to the value of the goods destroyed by fire is very unsatisfactory. The insured, Layne, had little or no experience in the mercantile business, and his books only showed in a haphazard way the amount of stock on hand and the sales. It appears, however, that when the goods were purchased by Layne on February 10, 1912, their value was estimated at \$2,050, and that at this price they were sold by Collingsworth to Layne. Collingsworth also testifies that goods to the value of about \$150 were not taken into consideration in fixing the price at \$2,050. He further testifies that there should be added to the value of the goods \$150 for cost of transporting the goods from the railroad to the store in which they were located; so that this would put the value of the goods at \$2,350. Soon after he bought the goods Layne purchased groceries amounting to \$324 and medicine amounting to \$10, which, added to the value of the goods at the time of the sale, would make \$2,684.

Layne told Evans, the Fire Marshal, that his sales would amount to about \$14 a day; and Norman, who clerked for Layne, said the sales would amount to between \$10 and \$30 a day for at least a few months. But if the average daily sale from the time of the purchase of the goods on February 10th until the time of the fire on October 10th should be put at \$6 a day, after deducting the profit made on the sales, it would appear that between the time of the purchase and the fire the value of the goods had been reduced \$1,272, which deducted from the value at the time of the sale, would leave the value of the goods at the time of the fire at \$1,412. The insurance only covered three-fourths of the loss, so that the value of the goods covered by the insurance would be \$1,059, and the amount due by the appellant company \$529.50.

Looking at the matter from any standpoint, we are confident

that the value here fixed equals fully the value of the goods destroyed by fire, for which the appellant was liable, if not more. It is true that what is called an invoice was taken of these goods in September, 1912, but this so-called invoice, although competent evidence in behalf of Layne, really throws no intelligent light on the value of the goods, and we put it entirely out of view in trying to estimate their value. In cases like this where the amount to which the insured is entitled is fixed by contract and depends on the value of the property insured at the time of the loss, the jury assessing the amount of recovery should not exceed the value of the property destroyed by the fire. The rule that we will not disturb a verdict unless it is flagrantly against the evidence, although it may be more than we think should be allowed, has very little application to cases like this. The insured should be able to show in some intelligent, satisfactory way the value of the loss he has sustained, so that the jury, in coming to make up their verdict, can fix the assessment at a sum within the limits of the policy sufficient to cover the actual loss sustained. This is all the insured is entitled to.

[3] Having reached the conclusion that the evidence for Layne shows that the loss he sustained was substantially less than the amount allowed by the jury, the judgment is reversed, with directions for a new trial.

SUPREME COURT OF MISSISSIPPI.

DIVISION B.

MITCHELL

vs.

ÆTNA INS. CO. (No. 17653.)*

INSURANCE—INVENTORY—CONDUCT OF AGENT—ESTOPPEL.
Where plaintiff, at the request of defendant's agent, furnished the agent an inventory of his stock of goods and merchandise in his store, containing the different articles of merchandise and the gross value of each, but not specifying the numbers, quantities, or prices, and the policy was issued upon such inventory, and the agent informed the insurer that it was all right and said nothing to plaintiff about its insufficiency, it was too late after the insurer had issued the policy, received the premium, and the insured property had been destroyed, for the insurer to say that the inventory did not satisfy a covenant

* Decision rendered, April 17, 1916. 71 South. Rep. 382.

and warranty contained in the policy as to an inventory; as it was estopped from doing so by its own conduct.
(For other cases, see Insurance, Cent. Dig. §§ 1037, 1038; Dec. Dig. § 390.)

Appeal from Circuit Court, Winston County; C. L. Dobbs, Judge. Action by J. T. Mitchell against the Aetna Insurance Company. Judgment for defendant, and plaintiff appeals. Reversed and remanded.

Flowers, Brown, Chambers & Cooper, of Jackson for Appellant. McLaurin & Armistead, of Vicksburg, for Appellee.

POTTER, J.

The appellant in this case, J. T. Mitchell, was plaintiff in the court below, and the Aetna Insurance Company was defendant.

This was a suit on a policy of insurance dated June 14, 1912; said policy being for \$1,700. This policy was issued through defendant's agent, insuring plaintiff's stock of goods against loss by fire. At the request of the appellee's agent, the appellant furnished him an inventory of his stock of goods and merchandise in his store in the town of Union, before the policy was issued. This inventory contained the different articles of merchandise carried by the appellant in his store, and the gross value of each article, but did not specify numbers, quantities, or prices. For example, the inventory read:—

Stock food	\$ 50.00
Poultry food	6.25
Patent medicines	150.00, etc.

The defendant insurance company set out in the notice of affirmative matter under its plea of the general issue that the inventory above mentioned did not satisfy the following covenant and warranty contained in said policy:—

"The assured will take a complete itemized inventory of stock on hand at least once in each calendar year, and, unless such inventory has been taken within twelve calendar months prior to the date of this policy, one shall be taken in detail within thirty days of issuance of this policy, or this policy shall be null and void from such date, and upon demand of the assured the unearned premium from such date shall be returned."

The above-mentioned inventory was prepared by the plaintiff for the defendant insurance company at the request of its agent, a Mr. Cole. The plaintiff testified that when the inventory was completed he carried it to Mr. Cole, and when he presented it to him that Mr. Cole said it was "all right." The insurance company contended in the court below that this was not a waiver on the part of the insurance company of the provisions of the policy requiring a complete itemized inventory of all of plaintiff's stock of goods, but that it was furnished its agent only as a basis of writing the policy of insurance in conformity with the three-fourths value clause contained in all standard policies. The court

below accepted the defendant company's view of this question, and gave a peremptory instruction in its favor.

We think this was error. The plaintiff was requested to furnish an inventory of his stock of goods. He made out the inventory as requested, and presented same to the defendant's agent. The policy of insurance was issued upon this inventory, and the agent informed the defendant that it was "all right." The agent knew that the plaintiff was furnishing him with a list of merchandise in his store upon which he desired to obtain insurance; and the agent knew that the plaintiff was undertaking to furnish him with an inventory thereof. When the policy was issued, the agent said nothing to plaintiff about the insufficiency of the inventory. It is too late now, after the company has issued the policy, received the premium, and plaintiff's property has been burned, upon which the insurance was carried, for the defendant company to say that the inventory in question was insufficient. It is estopped by its own conduct.

The judgment of the circuit court is therefore reversed and remanded.



SUPREME COURT OF MISSISSIPPI.

Division B.

PROVIDENCE-WASHINGTON INS. CO.

vs.

KENNINGTON. (No. 17659.)*

INSURANCE—FIRE INSURANCE.

A fire insurance policy provided that in event of disagreement as to the amount of loss or damage it should be determined by competent and disinterested appraisers before recovery could be had, that the insured and insurer should each select an appraiser, and the two should select a competent and disinterested umpire, and in the event of their failure to agree as to the damage the matter should be submitted to the umpire. Insured in good faith selected an appraiser, but he and the appraiser selected by the insurer were unable to agree on the amount of the damage or as to an umpire, the insurer's appraiser offering for umpire names suggested by the insurer's adjuster. Held that, as the insured acted in good faith, and as the policy did not provide for a second effort at appraisalment, insured might institute an action without any second offer of appraisalment; for, the provision being to the benefit of the insurer, it should be most strongly construed against it.

(For other cases, see *Insurance, Cent. Dig. § 1435; Dec. Dig. § 575.*)

* Decision rendered, April 17, 1916. 71 South. Rep. 378.

Appeal from Circuit Court, Hinds County; W. H. Potter, Special Judge.

Action by R. E. Kennington against the Providence-Washington Insurance Company. From a judgment for plaintiff, defendant appeals. Affirmed.

McLaurin & Armistead, of Vicksburg, for Appellant.
Watkins & Watkins, of Jackson, for Appellee.

STEVENS, J.

Appellee, as plaintiff in the court below, instituted this suit against appellant upon a contract of fire insurance covering a certain automobile owned by appellee in the city of Jackson. The policy of insurance, among other provisions, contained the following:—

"In the event of disagreement as to the amount of loss or damage the same must be determined by competent and disinterested appraisers before recovery can be had hereunder. The insured and this company shall each select one, and the two so chosen shall then select a competent and disinterested umpire. Thereafter the appraisers together shall estimate and appraise the loss or damage, stating separately sound value and damage, and failing to agree, shall submit to the umpire; and the award in writing of any two shall determine the amount of such loss or damage; the parties thereto shall pay the appraiser respectively selected by them and shall bear equally the expenses of the appraisal and umpire. * * *

"No suit or action on this policy, for the recovery of any claim, shall be sustainable in any court of law or equity unless the insured shall have fully complied with all the foregoing requirements."

There was a loss by fire, and the parties, being unable to agree upon the amount of damages, entered into an agreement for an appraisement in accordance with the provisions of the policy, Mr. Kennington selecting one H. C. Lawrence and the insurance company selecting Mr. Charles McDonnell, both of Jackson, Miss. The appraisers selected signed an appraisal agreement, and, being unable to agree as to the measure of damages, undertook to agree upon an umpire, but utterly failed to agree upon or to select an umpire under the terms of the policy. When the appraisers so selected failed to select an umpire, they abandoned their efforts toward executing the appraisal agreement, and each went about his own business. Mr. Kennington thereafter instituted this action to recover on his policy, and the defendant filed pleas challenging the right of the plaintiff to maintain this action until there has been appraisement and award in accordance with what the defendant contends to be the true meaning of the provisions of the policy above quoted. It appears that after the failure to agree upon an umpire neither party to the contract demanded new appraisers. It further appears from the evidence that the prin-

cipal difference between the appraisers selected was whether the umpire should be selected from citizens in or around Jackson, Miss., where Mr. Kennington lived and the loss occurred, or should come from another city or vicinity, and thereby should not be subject to local influence. It appears that the appraisers selected by Mr. Kennington submitted the names of several citizens of Jackson as also the name of one Mr. Lee, operating an automobile repair shop at Crystal Springs, Miss. The appraiser for the company submitted the names of several who lived in other cities in the state of Mississippi, as also the names of two residing in Jackson. The appraiser for Mr. Kennington found objections to the proposed umpire living in Jackson suggested by the company's appraiser, and objected generally to accepting an umpire from a distant city. There was evidence that many of the names suggested by the company's appraiser were suggested by appellant's adjuster, and that at the time these names were submitted appellant did not disclose to appellee's appraiser the fact that it had through its agents suggested any of these names.

The proof in this case shows that Mr. Kennington entered into the agreement for an appraisal in good faith; that he selected a disinterested and competent appraiser; that he left to his appraiser the responsibility and job of selecting an umpire; and that the failure to make an award was occasioned by no fault or negligence on the part of appellee. Under these circumstances, therefore, did appellee have the right of action on his policy? Under the terms of the contract here sued on we answer this question in the affirmative. In reference to the arbitration clause here in review there is conflict in the authorities. Many of the leading authorities hold that there must be a demand for arbitration before the insurer can complain of the other party's default in failing to seek appraisal and award. *Winchester vs. North British & Mercantile Insurance Co.*, 160 Cal. 1, 116 Pac. 63, 35 L. R. A. (N. S.) 404, and authorities there cited. Additional authorities on this point are collated in the elaborate brief of counsel for appellee. In the instant case there was an effort in good faith on the part of the plaintiff in the court below to arbitrate. The policy does not contain an express provision for an appraisal in the event the appraisers first selected failed to agree; and this provision of the policy, being one of the many printed provisions prepared by the insurance company and for its benefit, should not be enlarged or extended by any construction of this court. We prefer to adopt the more reasonable view that the insured, when he selects a competent and disinterested appraiser, discharges the obligation placed upon him. By his contract he agrees in event of loss to select for himself an appraiser who, in connection with the company's appraiser, determines the amount of the loss, or, failing to agree, selects an umpire. In estimating the loss the insured has no connection with the business

except to furnish needed information or evidence. He has nothing to do with selecting the umpire. If the appraisers fail to agree upon an umpire, then the appraisement has miscarried through no fault of the insured. The insured has suffered a loss, and has a right to a speedy recovery. If, therefore, there is no express provision in the policy for a second appraisement, or rather a second effort at appraisement, then the provisions in review should not defeat the right of the insured to enter the open door of the court for relief. The action is upon the policy contract, and the main inquiry is not whether there has been an appraisement, but whether there has been in deed and in fact a loss for which recovery should be had. Any provisions of a fire insurance policy seeking to impair the right of the insured to resort to the courts must be strictly construed against the company, and in the present case these provisions, in our judgment, do not require the insured to initiate a second effort at appraisement. If there must be a second effort at appraisement, there might be a third, and in the meantime justice might be delayed. Mr. Clement, in his work on Fire Insurance, vol. 1, pp. 159, 160, lays down as a part of rule 38:—

“Where appraisers, or a majority of them, fail to agree upon an award, plaintiff, unless he is shown to have acted in bad faith in selecting his appraiser, is not compelled to submit to another appraiser and another delay, but he may forthwith bring his action.”

In the case of *Western Assurance Co. vs. Decker*, 98 Fed. 381, 39 C. C. A. 383, the court says:—

“The contention of the company is that, when the arbitrators failed to agree, it was the duty of the insured to propose a new selection of arbitrators, and that, not having done so, and not having appointed an arbitrator a second time, he cannot maintain this action. The terms of the policy are satisfied when the assured, acting in good faith, appoints an appraiser. If the appraisal falls through by disagreement of the appraisers without any fault of the insured, he has discharged his covenant, and satisfied the requirements of the policy, and may then resort to the courts to have his damages assessed”—citing *Insurance Co. vs. Traub*, 83 Md. 524, 35 Atl. 13; *Pretzfelder vs. Insurance Co.*, 116 N. C. 491, 21 S. E. 302, 44 L. R. A. 424. “One of the fundamental and essential constitutional rights of the citizen is the right to appeal to a court of justice for redress of his grievances. One of the chief ends of government is to secure this right to the citizen. While some of the courts hold that the citizen may by contract bargain away this right, the agreement to do so will not be extended by construction or implication. Even if a second appointment of arbitrators was required by the terms of the policy, there is nothing in the policy, as contended by the defendant in error, which imposes upon the assured the obligation to be the first to propose another selection of arbitrators and appoint a second

arbitrator. * * * There is not a line or a word in the policy, making it the duty of the insured any more than the company to demand an appraisement and appoint an appraiser."

This announcement was afterwards reaffirmed by the same court in the case of Spring Garden Ins. Co. vs. Amusement Syndicate, 178 Fed. 519, 102 C. C. A. 29. There is force in the suggestion made by the court in the case of Winchester vs. North British & Mercantile Ins. Co., *supra*, that the insured submits his claim under oath, and that the insurer is the only party who can determine whether there are any differences, and therefore the only party in position effectually to demand an arbitration. It is certainly a provision which the company might waive.

"It has been held, on what seems to be the better reason, but where the assured has appointed an appraiser, and without his fault the appraisers fail to agree, he may maintain an action." Jerrils vs. German Ins. Co., 82 Kan. 320, 108 Pac. 114, 28 L. R. A. (N. S.) 104, 20 Ann. Cas. 251.

Counsel for appellant relies upon the case of Hamilton vs. Liverpool & London & Globe Ins. Co., 136 U. S. 242, 10 Sup. Ct. 945, 34 L. Ed. 419. The terms of the policy and the facts of that case, however, differentiate it from the case now before us. Indeed, the court, in that case by its concluding sentence, expressly reserved the question which here confronts us. The court says:—

"If the plaintiff had joined in the appointment of appraisers, and they had acted unlawfully, or had not acted at all, a different question would have been presented."

Aside from the question whether an award in this case was prevented by the wrongful or arbitrary conduct of the insurance company or its appraiser, a question which, in fact, was submitted to the jury under proper instructions, we rest an affirmance of this case upon the views above expressed.

Affirmed.



SUPREME COURT OF NEBRASKA.

WILKEN ET AL.

vs.

CAPITAL FIRE INS. CO. OF LINCOLN. (No. 18631.)*

2. INSURANCE—AGENTS—AUTHORITY.

A duly authorized agent of an insurance company sent an application for insurance in a specified amount upon specified property to a bank to be executed by the owners of the property. The owners of the prop-

* Decision rendered, May 13, 1916. 157 N. W. Rep. 1021. Syllabus by the Court.

erty signed the application and left it with the bank to be returned to the agent. The bank through some oversight failed to return the application to the agent for more than ten days. In the meantime the property was destroyed by fire, and the insurance company refused to pay the loss, solely because the application had not been received and approved and a policy issued before the fire occurred. Held, that the delay of the bank in forwarding the application must be considered as the act of the agent, for which the company is responsible, and that the question of the liability of the company for failure to duly act upon the application was for the jury.

(For other cases, see Insurance, Cent. Dig. § 199; Dec. Dig. § 130[4].)

Fawcett, Letton, and Rose, JJ., dissenting.

Appeal from District Court, Gage County; Pemberton, Judge.

Action by Chris Wilken and others against the Capital Fire Insurance Company of Lincoln. From judgment for defendant, plaintiffs appeal. Reversed and remanded.

Razlett & Jack and Walter Vasey, all of Beatrice, for Appellants.
G. E. Hager, of Lincoln, for Appellee.

SEDGWICK, J.

The plaintiffs bought of Nichols & Shepard Company at its office in Lincoln a threshing machine outfit. The machine was shipped to them at Adams, Neb., and received there about the 23d of June, 1913. The agreement was that the machine should be paid for by a note signed by the plaintiffs. A note for their signature, with other papers, was sent to the Farmers' State Bank of Adams by Miss Sherman, a bookkeeper in the office of Nichols & Shepard Company at Lincoln. With these papers she sent them an application for insurance upon the property in the defendant company. The plaintiffs signed the application for insurance, and also executed a note for the premium, and left the papers at the bank to be forwarded. Afterwards the property was destroyed by fire, and the company refused to pay the loss, on the ground that the application had not been approved and no policy had been issued. The plaintiffs brought this action in the district court for Gage County, alleging that they were damaged by the negligence of the defendant company in not acting upon the application and issuing the policy. The trial court instructed the jury to find a verdict for the defendant, and the plaintiffs have appealed.

[1, 2] It appears that Miss Sherman, the bookkeeper of the Nichols & Shepard Company, was the authorized agent of the defendant insurance company to take applications for insurance upon threshing machines sold by the Nichols & Shepard Company and to forward those applications to the defendant insurance company. The papers, with the application for insurance, were received at the bank about the 23d day of June, 1913, and very soon thereafter all of the plaintiffs, who were all of the purchasers of the threshing machine company interested in the insurance, except two, signed the application. The evidence fairly shows that these two also signed the application as early as the 15th of July.

The fire occurred on the 26th of July, and the bank, being notified of the destruction of the property by fire, immediately forwarded the application to Miss Sherman, the company's agent. She filled the blanks in the application correctly describing the property, and also filled other blanks and forwarded the same to the defendant company. The company returned the application, denying any liability, because the application had not been approved and no policy had been issued. It is not contended that there was any defect in the application or that the blanks had not been filled and the application completed by Miss Sherman, as contemplated by the parties. It is insisted on behalf of the defendant company that the bank was not its agent, and that no liability existed on the part of the company because of the negligence of the bank. It is undoubtedly true that the company's agent was not authorized to appoint a subagent for the company for the transaction of the company's business; but as is said in 31 Cyc. 1428:—

"Having exercised his discretion and determined upon the propriety of an act, an agent may delegate to a subagent the execution of merely mechanical, clerical, or ministerial acts involving no judgment or discretion; and the acts of such a subagent, to whom such power and authority have been delegated by the agent, are regarded as the acts of the agent himself, and are therefore as such binding on the principal."

It is clear that the delay of the bank in returning the application after it had been duly executed must be considered as though the delay had been by Miss Sherman herself after she had received the application from the bank. The evidence shows that the plaintiffs were responsible men. Their note was good and the risk was a desirable one for the company. The defendant company declined liability solely upon the ground that the application had not been approved and the policy issued, and there was no attempt to show that the risk was an undesirable one or would not have been accepted if the application had been duly received. A similar case was recently decided by the Supreme Court of Iowa. That court in quite an exhaustive opinion held the insurance company liable under very similar conditions. In that case the agent of the insurance company told the applicant for insurance that the notes given for the insurance would be returned if the application was rejected. The applicant then called upon the company's physician and was examined and was informed that he had passed a satisfactory examination. The company's agent had been in the habit of calling on the physician for the application with the examination, and the physician accordingly left these papers on his desk for the agent, but the agent neglected to call for the papers until the physician learned that the applicant had been drowned, whereupon the physician mailed the application to the company. The court said:—

"The association was bound by the acts of its agents and charge-

able with any consequences that resulted from the failure of Rogers (the agent) to promptly forward the application and physician's report. In other words, if the association was under a duty to promptly act on the application and notify Duffy (the applicant), as we think it was, it cannot shield itself from the responsibility by the fact that the application and medical report had not been received by it and therefore it could not act. See Northwestern Mutual Life Ins. Co. vs. Neafus, 145 Ky. 563, 140 S. W. 1026, 36 L. R. A. (N. S.) 1211. The possession of these by its agent had the same effect as if they were in the possession of the association at its home office. Assuming, then, that the application and medical report had been promptly forwarded by the agent, and that the application was not accepted or rejected within the time intervening prior to his death, it seems manifest that whether this was an unreasonable delay was for the jury to determine, and we so hold."

The court then considered the question whether it was negligence on the part of the applicant in not seeing that the application was duly returned and said:—

"The applicant had done all he could or was required to do in the matter. He had the right to assume that the application would be forwarded immediately after the medical examination and was so assured. * * * Moreover, about all he could have done was to withdraw his application and apply to another insurer for a policy, and this one who has applied to a company of his choice would quite naturally hesitate to do. Under the circumstances, it cannot be said, as a matter of law, that the deceased was at fault in not stirring defendant to action by inquiry as to the cause of delay or in not withdrawing his application. At the most, this also was an issue appropriate for the determination of the jury. * * * We think the jury might have found that, in all reasonable probability, had the association passed upon the application, it would have been accepted. * * * The association was actively soliciting members, and it seems to us that the record leaves little, if any, doubt but that, had the association ever passed on the risk, it would have been accepted and the certificate issued." Duffie vs. Bankers' Life Ass'n, 160 Iowa, 19, 139 N. W. 1087, 46 L. R. A. (N. S.) 25.

The court then quoted from Continental Ins. Co. vs. Haynes, 10 Ky. Law Rep. 276, as follows:—

"It is to be assumed that the company will accept the risk, if advantageous to it, which must be, if fairly and honestly contracted for, because that is the business in which it is engaged, and that is the object for which its agent acted, and therefore to allow it, under the reservation of the right to approve, to reject simply because a loss has occurred, would destroy the mutuality of the contract and inflict upon one party the misfortune he had provided against."

In St. Paul Fire & Marine Ins. Co. vs. Kelley, 2 Neb. (Unof.) 720, 89 N. W. 997, the action was upon an alleged contract of insurance. The agent had accepted payment of premium at less than the regular rate, and the application was returned for that reason. The loss occurred before the required premium was received by the company. It does not appear whether the applicant had made the additional payment of premium. There was no question of negligence or willful delay of the company in acting upon the application. The case is not in point.

The trial court, as a reason for the decision stated upon the record that:—

“Mr. Abbott (officer of the bank) had all his dealings with Nichols & Shepard Company until after the fire; he didn't know anything about this woman (the agent) at all until after the fire, and as far as I can see this woman did not have anything to do with this thing until after the fire.”

This refers to the fact that the letter in which the application was sent to the bank by Miss Sherman included also the papers between plaintiffs and the Nichols & Shepard Company, and purported to be written by the latter-named company. This reason does not appear to us to be controlling. It is not denied that Miss Sherman was the authorized agent of the defendant company. Indeed, it was so alleged in the defendant's answer. As such agent she inclosed the application in behalf of the defendant company. She intrusted to the bank a mere mechanical duty that any one could have performed for her, and the conduct of the bank in performing that duty must be considered as the act of Miss Sherman as the company's agent. The issues should have been submitted to the jury with proper instructions.

The judgment of the district court is reversed, and the cause remanded for further proceedings.

Reversed and remanded.

Fawcett, Letton, and Rose, JJ., dissent.



SUPREME COURT OF PENNSYLVANIA.

DALZELL

vs.

LONDON & LANCASHIRE FIRE INS. CO. OF LIVERPOOL, ENGLAND.*

INSURANCE—ACTIONS—TIME TO SUE—CONTRACT LIMITATION.

A fire policy provided that no action should be brought thereon unless commenced within twelve months after the loss. An action, brought in the common pleas court, was removed to the Circuit Court of the

* Decision rendered, Jan. 3, 1916. 97 Atl. Rep. 452.

United States, where plaintiff had a verdict. The judgment was reversed on appeal, without prejudice to the right to bring such other suit as plaintiff was entitled to prosecute. *Held*, a new action more than twelve months after loss cannot be maintained.

(For other cases, see *Insurance*, Cent. Dig. § 1548; Dec. Dig. § 622[6].)

Appeal from Court of Common Pleas, Allegheny County.

Action of assumpsit by John Dalzell against the London & Lancashire Fire Insurance Company of Liverpool, England, on a policy of fire insurance. From a judgment on a directed verdict for defendant, plaintiff appeals. Affirmed.

From the record it appeared that plaintiff brought an action on a fire insurance policy to recover \$2,150.37 in the common pleas court of Allegheny County on December 31, 1908. One of the provisions of said policy was as follows:—

"No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity * * * unless commenced within twelve months next after the fire."

On April 5, 1909, defendant removed the action to the United States Circuit Court and recovered a verdict; on appeal to the Circuit Court of Appeals, the judgment was reversed, "but without prejudice to the right of the plaintiff below to bring such other suit as he may be entitled to prosecute in whatever forum may have jurisdiction thereof." The present suit on the policy was brought in November, 1911, in the common pleas court of Allegheny County. Verdict for defendant by direction of the court, and judgment thereon. Plaintiff appealed.

Argued before Brown, C. J., and Mestrezat, Potter, Moschzisker, and Frazer, JJ.

Richard H. Hawkins, of Pittsburgh, for Appellant.

W. K. Jennings and D. C. Jennings, both of Pittsburgh, for Appellee.

PER CURIAM.

For the loss covered by the policy of insurance upon which the appellant brought this action he had previously brought suit in the court below, in 1908. That suit, in due course, reached the federal court for the Western District of Pennsylvania, and ultimately judgment was entered in the Circuit Court of Appeals in favor of the defendant. This was the end of all litigation between it and the appellant on the latter's present alleged cause of action. *Bolton vs. Hey*, 168 Pa. 418, 31 Atl. 1097; *Lafferty's Estate*, 230 Pa. 496, 79 Atl. 711; *Bower's Estate*, *Stephen's Appeal*, 240 Pa. 388, 87 Atl. 711. No right of action was saved to the appellant by the amended or modified judgment of the Circuit Court of Appeals, for the reason that he no longer had any right of action under the policy.

Judgment affirmed.

SUPREME COURT OF SOUTH CAROLINA.**HENDERSON***vs.***McMASTER, INS. COM'R, ET AL. (No. 9388.)*****3. CONSTITUTIONAL LAW—INSURANCE—EQUAL PROTECTION—REGULATION—STATUTES—VALIDITY.**

Act March 2, 1916, § 7, exempting the state warehouse commissioner from its operation as to discriminatory rates for insurance on property, applies only to that taken in his business as commissioner, and is not invalid as denying equal protection to other insurers.

(For other cases, see Constitutional Law, Cent. Dig. § 692; Dec. Dig. § 240[2]; Insurance, Cent. Dig. § 4; Dec. Dig. § 4.)

4. CONSTITUTIONAL LAW—CLASS LEGISLATION.

It is not unlawful to classify business and provide different rules for different classes.

(For other cases, see Constitutional Law, Cent. Dig. §§ 688, 693, 697, 698; Dec. Dig. § 240[1].)

5. CONSTITUTIONAL LAW—INSURANCE—EQUAL PROTECTION OF LAWS.

Act March 2, 1916, § 8, exempting mill mutuals and factory insurance from its operation, is not therefore unconstitutional classification; there being a valid distinction between mutual insurance and ordinary insurance.

(For other cases, see Constitutional Law, Cent. Dig. § 692; Dec. Dig. § 240[2]; Insurance, Cent. Dig. § 4; Dec. Dig. § 4.)

7. CONSTITUTIONAL LAW—INSURANCE—CONFUSION OF POWERS—POWERS OF COMMISSIONER.

Act March 2, 1916, § 6, authorizing the Insurance Commissioner to review rates, is not unconstitutional as conferring legislative and judicial duties on the Commissioner, but his duties are ministerial only.

(For other cases, see Constitutional Law, Cent. Dig. §§ 94-102, 144; Dec. Dig. §§ 62, 80[2].)

8. STATUTES—VALIDITY—SUBJECTS AND TITLES.

Act March 2, 1916, authorizing the Insurance Commissioner to review rates, is not unconstitutional under Const. art. 3, § 17, requiring the subject to be expressed in the title, because the title fails to state his authority; the general purpose and subject of preventing unlawful combinations being expressed.

(For other cases, see Statutes, Cent. Dig. § 144; Dec. Dig. § 113[3].)

9. STATUTES—VALIDITY—SUBJECTS AND TITLES.

Act March 2, 1916, prohibiting combinations of insurers and providing a penalty, is not unconstitutional under Const. art. 3, § 17, requiring the subject to be expressed in the title, because the title fails to mention a penalty, since a prohibition and penalty necessarily go hand in hand.

(For other cases, see Statutes, Cent. Dig. § 144; Dec. Dig. § 113[3].)

* Decision rendered, April 27, 1916. 88 S. E. Rep. 645.

10. MONOPOLIES—COMBINATIONS—PENALTY—VALIDITY.

Act March 2, 1916, prohibiting combinations of insurers, and requiring affidavits of rates, etc., is not invalid as providing a penalty for false swearing in excess of the Criminal Code provision as to perjury; it being competent to make such penalty heavier under certain circumstances, and Cr. Code 1912, § 344, allowing an additional penalty.

(For other cases, see *Monopolies*, Dec. Dig. § 30.)

12. CONSTITUTIONAL LAW—OBLIGATION OF CONTRACTS—INSURANCE.

The state cannot impair the obligation of an insurance contract, though the insurer be a foreign corporation.

(For other cases, see *Constitutional Law*, Cent. Dig. § 470; Dec. Dig. § 154[3].)

14. CONSTITUTIONAL LAW—RAISING CONSTITUTIONAL QUESTIONS—FOREIGN CORPORATIONS.

That a statute requires certain acts to be done by a foreign corporation a year hence is no ground for its withdrawal from the state on the enactment of the statute, and it cannot complain of loss of business during the year.

(For other cases, see *Constitutional Law*, Cent. Dig. §§ 39, 40; Dec. Dig. § 42.)

Original application for an injunction by David B. Henderson against Fitz H. McMaster, Insurance Commissioner, and another. Petition dismissed, and injunction refused.

T. Moultrie Mordecai and A. T. Smythe, both of Charleston, for Petitioner.

Thomas H. Peebles, Atty. Gen., and W. H. Townsend, of Columbia, for Respondents.

FRASER, J.

This is a case of very great importance. It is also a case in which there is a great popular interest. The case demands prompt decision. It should not be decided hastily, but without unnecessary delay. In view of the fact that there is such popular interest, the decision should be couched in such terms that the people who are not trained lawyers can understand the reason of the decision, without unnecessary citation of authority. Fundamental principles are sufficient. The Legislature of this state, at its recent session (1916), passed an act, entitled

"An act to prevent fire insurance companies or associations or partnerships doing a fire insurance business in this state to enter into any compact or combination with any other fire insurance companies, associations or partnerships."

This act gives the insurance commissioner of this state power to "review" rates of insurance, and provides punishment for false affidavits therein required. The petitioner comes into this court in its original jurisdiction, and alleges that he is a citizen of this state; that prior to the enactment of this statute he was doing an insurance business in this state, as the agent of the Liverpool & London & Globe Insurance Company of Liverpool, England, and

that by reason of the passage of this statute, the said insurance company was compelled, by reason of the provisions of said act, to cease to do business in this state; that the petitioner has, by reason thereof, been deprived of his business; that he knows no other business. He asks that the insurance commissioner be enjoined from proceeding to carry out the provisions of the act. The petitioner alleges that the act is unconstitutional in certain particulars. The insurance commissioner and Attorney General, who also has some duties to perform under the act and is a party hereto, demur to the petition. That is to say, these state officers come into this court and allege that, even admitting all the facts pleaded in the petition, still the petitioner has not shown that he is entitled to the injunction asked for. A copy of the act is set out in the case. It is not certified to, but is assumed to be a true copy of the act. The statute is alleged to be unconstitutional:—

[1] I. In that "the state warehouse commissioner is authorized to take any and all kinds of insurance on all classes of property, at any rates he may see fit, while the petitioner cannot accept any risk, and therefore is deprived of his property without due process of law, and is denied the equal protection of the law." A demurrer admits facts, but not constructions of statutes or conclusions of law or fact.

[2, 3] No such power is given to the state warehouse commissioner. The rule (no citation is necessary) in the construction of a statute is that general words—and it makes no difference how general—will be confined to the subject treated of. So here, the language, however general, would confine the insurance procured by or through the warehouse commissioner, to insurance procured by or through him in his business as warehouse commissioner.

[4, 5] It is also objected that the mill mutuals and factory insurance associations are exempted and this is said to be an unjust discrimination. It is not unlawful to classify business and provide different rules for the different classes. That insurance in which one party is insurer and the other the insured is not in the same class with mutual insurance, in which a person is both insurer and insured.

[6] If, however, these two provisions should be held to be unconstitutional, it would not affect this case, because the provisions are separable, and the rule is that the unconstitutional exception to a general provision fails, and the body of the act stands. In other words, if it is unconstitutional to exempt the state warehouse commissioner and the mill mutuals, then the business by and through the warehouse commissioner and the mill mutuals are not exempt from the provisions of the act.

[7] II. It is next objected that the act is unconstitutional, in that it confers both legislative and judicial powers on the insurance commissioner, and the Constitution provides that these

powers shall be kept separate. This act does not confer either power. The duties of the insurance commissioner are not legislative or judicial, but merely ministerial. *Carolina Glass Co. vs. State*, 87 S. C. 270, 69 S. E. 391. The right of the state to review insurance rates is not in issue.

[8] III. The next objection is to the title of the act, and it is claimed that the act does not conform to the title. The Constitution requires the subject to be expressed in the title. Article 3, § 17. There are three specifications here, but they really raise two questions:—

(a) It is said that there is nothing in the title to indicate that the commissioner is to be given power to review rates. It is not the function of the title to set out the entire act, but to declare the "subject." The details are in the act. The prevention of unlawful combinations, by requiring rates to be submitted to a commissioner or commissioners for review, is well recognized in both federal and state legislation. It is the well-recognized method by which unjust and discriminatory rates are prevented. No one should claim that the body of the act, which provides the details, contains a surprise when the Legislature has adopted the usual method.

[9, 10] (b) It is objected that the act provides a penalty, and there is no mention of a penalty in the title. When an act forbids the doing of a thing and provides no penalty for its violation, the act is wholly ineffective. An act to prevent and a penalty go hand in hand. It is said that the penalty for false swearing, under this act is made more severe than perjury in other cases, and this cannot be allowed. This objection is untenable. There is no reason why perjury, under some circumstances, may not be more severely punished than perjury under other circumstances. It is common to fix a maximum and a minimum punishment, both as to fine or imprisonment, or fine and imprisonment, and to allow the trial court a discretion to fix the amount of fine and imprisonment, or the fine or imprisonment. Besides this, section 344 of the Criminal Code allows an additional punishment for perjury of seven years, with no option to pay a fine.

[11, 12] IV. The insurance commissioner and Attorney General have raised tentatively the question as to the right of the petitioner to raise the questions made in this case, but do not insist upon it. We will consider the question so far as it affects the merits of the case. No citizen of this state can have a vested right (as between himself and the state) in a contract to carry on business as agent of a foreign corporation within this state, because a foreign corporation can do business in this state only by permission of the state and can continue to do business within the state only so long as the state permits it. If a citizen of this state had any vested right, then all that a foreign corporation would have to do would be to make contracts for 50 years with some citizens as

its agents and the power of the state to rid itself of the corporation within the 50 years would be destroyed. This position is untenable. This principle does not apply to contracts of insurance already made between citizens of this state and foreign insurance companies; nor to contracts of insurance hereafter made between citizens of this state and such foreign insurance companies who are not doing business in this state.

[13, 14] It is said that by reason of this act the Liverpool & London & Globe Insurance Company has been compelled to withdraw from business in this state. That is a statement of a conclusion of fact, and not admitted by the demurrer. The facts stated in the record do not bear out the conclusion that this company was compelled to withdraw from business in this state by reason of the act of the Legislature. This company has already withdrawn from the state. The affidavit as to unlawful combinations is not required to be filed now. It is to be filed March 1, 1917 (the act contemplated a year and the necessary delay must be added), and that affidavit is for a renewal of the license to do business for another year. That affidavit is that they have not entered into an unlawful agreement within the year. That feature, therefore, can have had no legitimate effect on its withdrawal in 1916.

[15] The objection to the other feature of the act, that rates shall be submitted to the insurance commissioner in order that he may see that they are not discriminatory or unjust, leads inevitably to one of three propositions: (1) It is impracticable to get a fair and just review of rates in this state; or (2) the insurance company desires to make discriminatory and unjust rates; or (3) a denial of the right of the state to impose any conditions on its right to do business here. There is nothing in the petition to sustain either of the three propositions.

[16] The Constitution (article 9, § 13) requires the Legislature to enact laws to prevent agreements against the public welfare. The Legislature must primarily determine what agreements are against the public welfare.

The petition is dismissed, and the injunction refused.
Gary, C. J., and Hydrick, Watts, and Gage, JJ., concur.

**COURT OF CIVIL APPEALS OF TEXAS.
GALVESTON.**

FIRE ASS'N OF PHILADELPHIA

vs.

PERRY ET AL. (No. 7092.)*

1. INSURANCE—CHANGE IN INTEREST IN PROPERTY—CONDITIONAL SALE—SUFFICIENCY OF EVIDENCE.

Evidence in an action on a policy of fire insurance, covering certain billiard and pool tables situated in a certain building, providing that any change, other than by the death of the insured, in the interests, title, or possession of the subject of insurance, except change of occupants without increase of hazard by the voluntary act of the insured, should avoid the policy, held to show that, after its issuance, the insured had made a conditional sale of the property on the security of a chattel mortgage and had received payments of part of the buyer's notes before the loss.

(For other cases, see Insurance, Cent. Dig. §§ 1711-1716; Dec. Dig. § 665[3].)

2. INSURANCE—FORFEITURE—PLACE OF CONDITION—INTEREST IN PROPERTY.

Under such policy, a conditional sale before the loss was a change other than by the death of the insured in the interest, title, and possession of the insured property avoiding the policy and defeating the insured's recovery thereon.

(For other cases, see Insurance, Cent. Dig. § 799; Dec. Dig. § 328[5].)

Appeal from District Court, Harris County; Wm. Masterson, Judge. Action by Rene Perry and another against the Fire Association of Philadelphia. Judgment for plaintiffs, and defendant appeals. Reversed and judgment rendered for defendant.

Gill, Jones & Tyler, of Houston, for Appellant.

Robert & Sears, and C. M. Fairchild, all of Houston, for Appellees.

LANE, J.

This suit was instituted by Misses Rene Perry and Nora Perry against the Fire Association of Philadelphia, an insurance corporation, hereinafter called Insurance Company, to recover upon a certain policy of fire insurance for \$2,000, issued by said Insurance Company to Rene and Nora Perry on the 23d day of January, 1913, which covered certain billiard and pool tables, balls, cues, etc., claimed by plaintiffs, situated in a certain building in Houston, Tex.

The defendant Insurance Company answered, admitting the execution and delivery of said policy, but it says that said policy contains, among other things, the following clause:—

* Decision rendered, March 16, 1916. 185 S. W. Rep. 374.

"This entire policy, unless otherwise provided by agreement indorsed hereon or added hereto, shall be void if the hazard be increased by any means within the control or knowledge of the insured; or if the interest of the insured be other than unconditional and sole ownership; or if the subject of insurance be personal property and be or become incumbered by a chattel mortgage; or if, with the knowledge of the insured, foreclosure proceedings be commenced or notice given of sale of any property covered by this policy by virtue of any mortgage or trust deed; or if any change, other than by the death of an insured, take place in the interest, title or possession of the subject of insurance (except change of occupants without increase of hazard) whether by legal process or judgment or by voluntary act of the insured, or otherwise."

It further says that, if plaintiffs ever acquired the unconditional ownership of the property described in said policy, they sold the same to their brother, L. E. Perry, on or about the 1st day of February, 1913, and received in payment therefor from the said L. E. Perry his 20 promissory notes for the sum of \$150 each, numbered from 1 to 20 inclusive, all dated at Houston, Tex., February 1, 1913, and payable respectively on March 1, 1913, and monthly thereafter until all are paid; that said notes were delivered by said L. E. Perry to plaintiffs, and that they accepted same in payment for an interest in said property; that during the period from the date of said notes, to wit, February 1, 1913, to the date of the fire which destroyed the insured property, five of said notes were paid to plaintiffs, and that by each of said payments a change in the title or interest of plaintiffs in said property described in said policy occurred, and that, at and prior to the time of the fire which destroyed said insured property, an interest in the same had passed from plaintiffs to L. E. Perry, and that at the time of the fire plaintiffs were not the unconditional owners of said property; that plaintiffs, under the conditional sale hereinbefore mentioned, placed L. E. Perry in possession of said property, and thereafter L. E. Perry conveyed an interest therein to one B. H. Tinsley, who, together with said L. E. Perry, in conducting a billiard and pool hall business, took possession of all said insured property on the 1st day of February, 1913, which business they continued up to the time of the fire which destroyed said property, under the following contract:—

"Know all men by these presents: That we, L. E. Perry, of the county of Harris and state of Texas, and B. H. Tinsley, also of said county of Harris, state of Texas, do hereby agree and do hereby make these our articles of agreement, and do enter into a partnership on equal shares, and do hereby agree, covenant and stipulate as follows:—

"(1) The partnership business is to conduct a billiard and pool hall now situated at No. 1915½ Preston Avenue in the city of Houston, and known as the Brunswick Billiard Parlor, and same

shall be the style of our firm name and under which we propose to conduct business.

"(2) Whereas, said billiard and pool business is now owned by said Perry by virtue of a bill of sale from Misses Rene and Honora Steele Perry, who bought same from J. S. Taylor; and whereas, said Misses Perry had made their bill of sale to said Perry, and said Perry has given to said Misses Perry a chattel mortgage on said business and all personal property therein to secure the whole of the purchase price, to wit, \$3,000, which is payable in 20 installments of \$150 each, payable monthly, with interest thereon from February 1, 1913, the date of said notes, at the rate of 10 per cent per annum; and whereas, we each expect to pay off said notes as they fall due from the money taken in from conducting said billiard parlor; and whereas, we each agree to put in our personal time and attention to said business, at such hours as we may agree upon, and to devote our energies to making said business pay: Now, therefore, in consideration of the premises and in consideration of \$1, the receipt of which is hereby acknowledged, the said L. E. Perry has bargained, sold, and conveyed and delivered, and does by these presents hereby bargain, sell, and convey and deliver, unto the said B. H. Tinsley, an undivided one-half interest in and to said business as described in said bill of sale made to said L. E. Perry, the same consisting of the following described personal property, to wit: All the personal property now contained in the billiard hall known as the Brunswick Billiard Parlor, at No. 1915½ Preston Avenue, in the city of Houston, in said Harris County, Tex., including the right to use said name, and also the good will of said business, the property therein contained being all that is now therein, and being the same so purchased by me from said Misses Perry, consisting in part of two billiard tables, ten pool tables, balls, bridges, cues and racks, chairs, a safe, a cash register, and a cigar case, and stove, to have and to hold unto the said B. H. Tinsley, his heirs and assigns, forever. This sale is, however, subject to said mortgage given by me to said Misses Perry, it being our understanding that we are going in together to buy this place, and to that end try to earn enough together in said business to pay off said mortgage and notes, so that when that is done we shall be equal partners and equally own said business and property.

"(3) We each agree that out of the money taken in from said business each month, that we pay off one of said notes with interest due thereon, and that we will try to be economical in conducting said business and in our expenses, so that we may be able to meet each note as it falls due. Neither party can sell their interest except by mutual agreement in writing. Not over \$10.00 a week to be drawn.

"(4) The said Perry agrees to execute and deliver to the said Tinsley an unconditional bill of sale to an undivided one-half of

said property, when same shall have been paid in full according to the terms of this agreement by the said Perry and the said Tinsley, and after same is released from said mortgage.

"(5) This contract of partnership is executed in duplicate. This the 1st day of February, A. D. 1913.

"(Signed) L. E. Perry.
B. H. Tinsley."

That by reason of the facts hereinbefore alleged and otherwise, the interest of the insured in the property described in said policy was not the unconditional and sole ownership at the time of the issuance of said policy, nor at any time thereafter, nor at the time of the fire, if any, and that a change other than by the death of the insured, or either of them, took place in the interest, title, and possession of the subject of insurance in violation of the conditions, stipulations, provisions, and warranties contained in said policy, and hereinbefore set forth, whereby said policy became and is null and void according to its terms. Defendant further says that by reason of the facts above alleged and otherwise, and independently thereof, the provisions, stipulations, conditions, and warranties in said policy, as hereinbefore set forth, were breached by the plaintiffs herein prior to the 28th of July, 1913, either because the interest of the insured was other than the unconditional and sole ownership of the subject of insurance at the time of the issuance of said policy, and at all times thereafter, or else because after the issuance of the policies sued on a change took place in the interest, title, and possession of the subject of insurance, and in the interest, title and possession of the subject of insurance (other than a change of occupants without increase of hazard) by the voluntary act of the insured prior to the date of the fire, if any, whereby said policy became and is null and void and unenforceable. That the policy sued on is void and unenforceable, according to its terms, because the interest of the insured in the property was not truly stated herein; because the interest of the insured therein was not the unconditional and sole ownership; and because by the voluntary act of the assured after the issuance of the policy and prior to the fire, if any, a change other than by the death of the insurer took place in the interest, title, and possession of the subject of insurance other than a change of occupants without increase of hazard, all in violation of the conditions, provisions, stipulations, and warranties in said policy hereinbefore set forth. That each and all of said violations and breaches aforesaid were material both to the risk and the rate, and the compliance with each and all of the above-mentioned conditions, provisions, and stipulations were conditions precedent to any recovery on said policy, and were promissory warranties on the part of the insured, the violation of which avoided the policy.

Appellees' contention is that they were at all times from the date

of the policy of insurance to the date of the fire the sole and unconditional owners of the insured property; that they had only placed L. E. Perry in charge of the pool hall business as their manager, with the understanding, however, that if he, L. E. Perry, would quit drinking and live with his wife—in other words, live with his wife and live a moral life—and pay them back the \$3,000 paid by them for the property, they would give the property to said L. E. Perry, but that the title to said property remained in them absolutely and unconditionally until said L. E. Perry had complied with the conditions above stated.

Appellant's contention is that the plaintiff purchased said pool hall business for their brother, L. E. Perry, and agreed and contracted with him that if he would take possession of said business and pay them \$150 per month, as evidenced by certain notes executed and delivered by said L. E. Perry to plaintiffs, until \$3,000 and interest thereon shall have been paid, they (plaintiffs) would convey said property to said L. E. Perry, and that under said agreement the property was turned over to said L. E. Perry, who thereafter, in undertaking to carry out his part of said agreement or contract, paid to plaintiffs five payments of \$150 each, and that plaintiffs accepted such payments as a part compliance with said agreement on the part of L. E. Perry and canceled and returned one of said notes upon each payment; that by reason of the transactions and agreement above mentioned an interest in said insured property in fact passed from plaintiffs to said L. E. Perry, and therefore plaintiffs were not the unconditional and sole owners of the insured property at the time of the fire which destroyed same, and under the terms of the policy sued upon they are not entitled to a recovery in this cause.

The case was tried by a jury upon special issues submitted to them by the court, and they found that plaintiffs were the unconditional owners of the property insured and destroyed by fire, and also found all other issues submitted to them in favor of plaintiffs. Upon the findings of the jury the court rendered judgment in favor of plaintiffs against said Insurance Company for \$2,000, and interest thereon from date of judgment. From this judgment the Insurance Company has appealed.

Appellant's first assignment is as follows:—

"The court erred in refusing to give defendant's specially requested instruction No. 1, being a request for a peremptory instruction as follows: 'You are instructed to return a verdict in this case in favor of the defendant, Fire Association of Philadelphia, that plaintiffs take nothing by their suit against it',—because the undisputed evidence affirmatively shows that a change, other than by the death of the insured, took place in the title and interest of the insured in the subject of insurance by the voluntary act of the insured after the issuance of the policy, and before the fire,

whereby the policy sued on became null and void and unenforceable."

The disposition of this assignment requires a careful consideration of the evidence most favorable to the plaintiffs, and should such evidence show that after the issuance of the policy sued on, and before the fire which destroyed the property insured, plaintiffs made a conditional sale of said property to L. E. Perry, they cannot recover in this suit. Therefore we deem it advisable to here set out the substance of plaintiffs' evidence upon the question of such sale, which we here do, as follows:—

Miss Rene Perry testified:—

"I am one of the plaintiffs. * * * I closed the deal on behalf of my sister and myself for the pool and billiard room business located at Preston and Fannin. * * * We bought for ourselves as far as money in itself was concerned, but I bought the business for my brother, trying to give him something to really make something out of himself. I put in my brother, Edgar Perry, as manager. His duties were to see that the poolroom was run properly. He had charge of it and ran it for us. That place was destroyed by fire about the 28th of July. I had the policy of insurance."

On being questioned as to a sworn statement made by her before a notary public as to the ownership of the property in question, she said:—

"That is my signature to the sworn examination. I don't recall reading the paper over. I know I signed it in Mr. McCarthy's office here in the courthouse and swore to it. I didn't state that I swore to it without taking the time to read my testimony of three pages, I say I did not recall whether I did. As to whether or not the report of this examination, as written here, is correct, there was one question here that my explanation was not put in at all. * * * In answering the question, 'What was the consideration your brother, L. E. Perry, was to pay you and your sister for the pool and billiard equipment?' the sworn statement shows my answer was, '\$3,000 including 10 per cent interest.' With reference to this question and answer I said: 'When I drew out the \$3,000, there was no question of interest when I drew out the \$3,000. We put in the business, and if Edgar had made good at that time, then I would give him the place for himself without any further compensation from him.' I wanted to cut out the word 'interest'. There was no question of interest, because I have never gotten any interest of any kind. With that addition the question and answer are correct."

In answering the question in the sworn statement, "How was he to pay you the \$3,000?" her answer is shown to have been, "Take up the notes." In explanation of this answer she said, while testifying at the trial:—

"Mr. Bucklew insisted on putting in 'Take up the notes.' That

reads like I said it. As to whether or not I said, 'Take up the notes at \$150 per month,' I now answer, in using them as receipts, because they were not notes. * * * I did add to that answer (which was not inserted), 'They were not notes, it was \$150 a month I was to draw out of the business, that I had as my interest in the business.'

The witness further testified that the notes were to bear 10 per cent interest, but they were never considered by her as notes. Five of these notes were taken up by L. E. Perry, and that she delivered them to Perry as receipts and not as notes. She testified that she had put in \$3,000 and had only drawn out \$150 a month for five months, and that she was to draw out her full \$3,000, and that after she had realized that much, and if Edgar made good, the business was his as at present. On being asked if she had not stated on her sworn examination that the notes referred to were the ones executed by L. E. Perry, she answered that they are, and that she had nothing to add to such answer.

The twenty notes referred to by their terms were to be paid one each month until all of them were paid, and, omitting dates of payment, read as follows:—

"150.00. Houston, Texas, Feby, 1st, 1913.

"* * * after date, for value received, I promise to pay to the order of Rene Perry and Honora Steele Perry, one hundred and fifty dollars at Houston, Texas, with 10 per cent interest per annum from date until paid.

"And in the event default is made in the payment of this note at maturity, and it is placed in the hands of an attorney for collection, or suit is brought on the same, then an additional amountnt of ten per cent on principal and interest of the note shall be added to the same as collection fees.

"Due——, 1913.

L. E. Perry."

The witness was asked, "Did you furnish any inventory other than the bill of sale referred to from Taylor to you, to your brother, L. E. Perry, when you sold him the billiard and pool equipment?" and she answered, "No, sir." At the trial she testified that the question and answer as above set out is correct and that the answer then given is still her answer. The witness was then asked if the following question and answer were not asked and given in the examination referred to, to wit:—

"Q. Then the agreement between your brother, sister, and yourself was that you were to transfer to him all the billiard and pool equipment that you purchased from J. S. Taylor, and you were to receive twenty notes, of \$150 each, payable monthly, bearing intérêt at ten per cent per annum from date on each note, is that right? A. That has the same explanation. I said, 'Yes, sir,' and I explained and gave the same explanation I have used throughout this testimony. I made the answer, 'Yes, sir', to the question, 'And upon that verbal agreement did you deliver to your

brother, L. E. Perry, deliver and turn over to him, all the billiard and pool equipment purchased from J. S. Taylor, to be used and handled as he saw fit for his own benefit, when he delivered to you the twenty notes above referred to?" My whole answer was, 'Yes, sir; when he took those all up and when he made good. The next question and answer, 'Had you any mortgage other than those notes against the property?' to which I answered, 'No, sir,' is correct. By the words, 'if Edgar made good,' I mean if he had quit drinking entirely and treated his wife properly and lived with her properly as he should have done; in other words, be a real man—that is what I meant by making good. I don't mean the business. I am talking about him himself. The business was not to be his until he did do that; that is, until he did those two things—treated his wife properly, that is, lived with his wife, go back to his wife, and quit drinking. Those were the two things. This trade changed before the fire because I came very near taking the business away from him twice. That understanding stood from the time I first put him until the fire. We never changed our agreement. I was perfectly willing to give it to him if he would make good. There was no change up to the time of the fire."

That the contract between L. E. Perry and Tinsley, as hereinbefore set out, was executed, and that the parties thereto were acting thereunder with reference to said billiard and pool hall business from the date of its execution, to wit, on the 1st day of February, 1913, there is no dispute.

L. E. Perry testified for plaintiffs and substantially supported the testimony of Miss Rene Perry with reference to the agreement between her and him, as to his right in the property. Both L. E. Perry and B. H. Tinsley testified that the earnings of the business were about \$850 to \$900 per month; that the expenses were about \$266 per month, and that Miss Perry was paid \$150, or about that sum, each month; that the difference between the expenses and the amount paid Miss Perry and the earnings went into the business, and that during the time they were in charge of the business they had bought a billiard table and other property and added it to the business before the fire.

L. E. Perry also testified:—

"I bought the new stuff in my own name. It is mortgaged in my name in the county clerk's office."

[1] A careful examination of the evidence in this case will show that the following facts are firmly established by the testimony of the plaintiff and her witnesses, and are admitted to be true: That is, that the insured property was purchased by plaintiffs from J. S. Taylor on the 22d day of January, 1913, for their brother, L. E. Perry; that the policy sued on was dated January 23, 1913; and that on February 1, 1913, plaintiffs placed their brother, L. E. Perry, in possession of the property, under the agreement, understanding and arrangement that if \$3,000 were

paid to plaintiffs by L. E. Perry in monthly payments of \$150 per month, and if meantime L. E. Perry had refrained from drinking and lived with his wife, the property would be his.

The sum and substance of the testimony of the plaintiff Miss Rene Perry is that she bought the business for her brother, L. E. Perry; that she had paid \$3,000 for the same; that L. E. Perry had paid her five payments of \$150 each under the agreement between them that she was to be repaid the \$3,000 she had put into the business; that after said \$3,000 was paid and if L. E. Perry quit his bad habits and returned to his wife to live with her, the business was to be his.

We think no other conclusion can be reached than that a conditional sale of the property had been made by the Misses Perry to L. E. Perry on the 1st day of February, 1913, and that he was carrying out his part of the agreement at the time of the fire which destroyed the property; that, had the property not been destroyed, L. E. Perry could have carried out his part of the agreement between himself and his sisters and have become the sole owner of the property; and that his sisters, plaintiffs herein, could not, over his protest or objection, have arbitrarily canceled said agreement.

[2] We therefore conclude that by the voluntary contract or agreement of the plaintiffs there was a change, other than by the death of the insured, in the interest, title, and possession of the insured property, and in view of the fact that the policy of insurance provided that "if any change, other than by the death of an insured, take place in the interest, title, or possession of the subject of insurance, the entire policy shall become void," plaintiffs cannot recover in their suit upon said policy, and it therefore follows that the court erred in not rendering judgment for defendant, Fire Association of Philadelphia. *East Texas Fire Ins. Co. vs. Clarke*, 79 Tex. 23, 15 S. W. 166, 11 L. R. A. 293; *Rochester German Ins. Co. vs. Schmidt*, 162 Fed. 447, 89 C. C. A. 333, May on Insurance, par. 287; *Hartford Fire Ins. Co. vs. Keating*, 86 Md. 130-145, 38 Atl. 29, 63 Am. St. Rep. 499; *Fire Association vs. Flournoy*, 84 Tex. 632, 19 S. W. 793, 31 Am. St. Rep. 89; *Phoenix vs. Quinette*, 36 Okl. 384, 128 Pac. 722.

In the case of *East Texas Fire Ins. Co. vs. Clarke*, supra, in discussing a similar provision in a fire insurance policy, our Supreme Court says:—

"The word 'interest,' as defined in Abbott's Law Dictionary, means 'any right in the nature of property but less than title. Its chief use seems to designate some right attaching to property which either cannot or need not be defined with precision.'"

In the case of *Fire Association vs. Flournoy*, supra, it is said:—

"It appears from the evidence on the 31st day of January, 1888, Brady Bros. and Tinkle & Black entered into a written contract, in consideration of \$400 paid to Brady Bros., and other pay-

ments to be made by Tinkle & Black, whereby Brady Bros. leased to Tinkle & Black, for the term of three years, commencing February 1, 1888, all the property covered by the policy. The agreement states the time and amount of each subsequent payment, and contains this stipulation: 'It is further hereby expressly understood and agreed by and between the parties to this contract that should the party of the second part, on or before November 3, 1888, pay to party of the first part an additional sum of \$26.85, then and in that case the party of the first part doth hereby sell, transfer, and convey unto the party of the second part the absolute title and ownership of all of said furniture and property.' By the terms of the policy it is provided 'that, if any change takes place in the title, interest, or possession of the property, except in case of succession by reason of the death of the assured, whether by sale, transfer, or conveyance, in whole or in part,' etc., it shall become void. The court instructed the jury that the contract between Brady Bros. and Tinkle & Black created a change in the title to the property. We think this a proper construction of the contract. *Insurance Co. vs. Clarke*, 79 Tex. 24, 15 S. W. 166 (11 L. R. A. 293); *Smith vs. Insurance Co.*, 3 Cal. Unrep. Cas. 244, 23 Pac. 384."

[3] Appellees contend, however, that if it be assumed that the contract between Miss Perry and L. E. Perry was one otherwise enforceable, L. E. Perry was never entitled to specific performance, because acts on his part remained to be done which no court could force him to do; that if it be admitted that Miss Perry contracted to sell the property to L. E. Perry if he paid \$3,000 in monthly installments of \$150, quit drinking and lived with his wife, such conditions could not be enforced as against L. E. Perry, and therefore the necessary elements of mutuality is lacking.

We cannot altogether agree to such contention. The undisputed evidence shows that L. E. Perry paid to appellee \$750 of the money consideration named in the contract or agreement between himself and his sisters, and so far as the evidence discloses was fully performing his part of the contract at the time of the destruction of the property.

In the case of *Halff Company vs. Waugh*, 183 S. W. 839, decided by this court on the 20th day of January, 1916, it is said:—

"It is true that the contract does not bind the defendant to perform any of its provisions, and that it is for this reason unilateral; but the mere want of mutuality did not render the contract unenforceable after defendant had accepted * * * the truck, and in all things performed his part of the agreement, especially after he had paid \$729.83 in part performance, and offered to strictly carry out its terms until the full purchase price of the truck should be paid. *Hawratty vs. Warren* (18 N. J. Eq. 124), 90 Am. Dec. 613; *Pittsburg Brick Co. vs. Bailey* (76 Kan.

42, 90 Pac. 803), 12 L. R. A. (N. S.) 745; Allegheny Oil Co. vs. Snyder (106 Fed. 764) 45 C. C. A. 604; Schroeder vs. Gemeinder, 10 Nev. 355; McAfee vs. Crubb, 164 S. W. 925."

We think the rule laid down in the above quotation a sound one. If it were not so, then in this case Miss Perry would have had the right to declare her agreement with her brother, L. E. Perry, at an end, and have taken possession of the billiard and pool hall at any time, even after L. E. Perry had, in strict conformity to the terms of said agreement, paid all but one monthly payment of \$150, and had up to the time of the fire fully complied with all other provisions of said agreement. We think it was clearly contemplated that L. E. Perry should be the owner of the property in question at the end of 20 months if he paid \$150 per month until the \$3,000 was paid, and had during this time quit drinking and lived with his wife.

What we have already said, and in view of the disposition we shall make of the case under appellant's first assignment, renders a consideration and discussion of the remaining assignments unnecessary.

As it appears that the case was fully developed, and it further appearing that plaintiffs were not entitled to recover, and that defendant was entitled to a preemptory instruction, the judgment of the trial court in favor of plaintiffs is here reversed and judgment is rendered for defendant.

Reversed and rendered.



SPRINGFIELD FIRE & MARINE INS. CO. *vs.* FERRELL.

(6 Div. 13.)*

(Court of Appeals of Alabama.)

3. INSURANCE—AGENT FOR INSURER—IMPLIED AUTHORITY —EVIDENCE AS TO LIMITATION OF AUTHORITY.

Where it was agreed that an insurance agent's authority was limited to one county, and that on a trip into another county he solicited insurance generally and wrote one policy accepted by the company, which did not know of the trip and did not hold him out as their agent in the second county, *held*, that the company was not liable for the agent's retention of premium paid for policy applied for in the second county.

(For other cases, see Insurance, Cent. Dig. § 123; Dec. Dig. § 93.)

Appeal from Circuit Court, Cullman County; Robert C. Brickell,
Judge.

* Decision rendered, April 13, 1916. 71 South. Rep. 615.

Action by G. F. Ferrell against the Springfield Fire & Marine Insurance Company. From a judgment for plaintiff, defendant appeals. Reversed and remanded.

A. A. Griffith, of Cullman, and Callahan & Harris, of Decatur, for Appellant:

Sample & Kilpatrick, of Cullman, and J. B. Powell, of Jasper, for Appellee.



**CONCORDIA FIRE INS. CO. ET AL. vs. MITCHELL.
(No. 198.)***

(Supreme Court of Arkansas)

2. INSURANCE—FIRE INSURANCE—ACTIONS—EVIDENCE.

In an action on a fire policy, evidence *held* to warrant the jury in finding that the soliciting agent was required to report losses, and that the insured was warranted in relying on such agent's representations as to the authority of one introduced as an adjuster.

(For other cases, see Insurance, Cent. Dig. § 122; Dec. Dig. § 92.)

3. INSURANCE—FIRE INSURANCE—ACTIONS.

Where an agent authorized to solicit and write fire insurance and required to report losses represented to insured that the person whom he introduced was an adjuster, the insurer is bound by the purported adjuster's waiver of proofs of loss other than an itemized list of property destroyed; the soliciting agent apparently acting within the scope of his authority.

(For other cases, see Insurance, Cent. Dig. §§ 1374, 1376, 1377; Dec. Dig. § 556[1].)

Appeal from Circuit Court, Hempstead County; Geo. R. Haynie, Judge.

Actions by J. W. Mitchell against the Concordia Fire Insurance Company and another, which were consolidated. From a judgment for plaintiff, defendants appeal. Affirmed.

Allen Hughes and W. W. Hughes, both of Memphis, Tenn., for Appellants.

Steve Carrigan, Jr., of Hope, and L. F. Monroe, of Washington, Ark., for Appellee.

* Decision rendered, Feb. 21, 1916. 183 S. W. Rep. 770.

**MANGRUM & OTTER, INC., vs. LAW UNION & ROCK
INS. CO. (S. F. 6609.)***
(Supreme Court of California.)

**INSURANCE—CANCELLATION OF POLICY—CONDITIONS
PRECEDENT—RETURN OF PREMIUM.**

Under a fire insurance policy in the New York standard form providing that it might be canceled at any time at the request of the insured, or by the insurer by giving five days' notice of such cancellation, and that if the policy should be canceled as provided the unearned part of the premium actually paid should be returned on surrender of the policy or last renewal, the insurer retaining the customary short rate, except that on a cancellation by it by giving notice it should retain only the pro rata premium, the giving of the five days' notice was sufficient to cancel the policy, and the return of or offer to return the premium was not an essential element of the cancellation.

(For other cases, see Insurance, Cent. Dig. §§ 509-512; Dec. Dig. § 230.)

In Bank. Appeal from Superior Court, City and County of San Francisco; J. A. Plummer, Judge.

Action by Mangrum & Otter against the Law Union & Rock Insurance Company. Judgment for plaintiff, motion for new trial denied and defendant appeals. Judgment and order reversed.

Goodfellow, Eells & Orrick, of San Francisco, for Appellant.
J. F. Riley, of San Francisco, for Respondent.

* Decision rendered, April 19, 1916. Rehearing denied, May 18, 1916.
157 Pac. Rep. 239.



MANIS vs. PRUDEN. (No. 419.)*

(Supreme Court of Georgia.)

**1. INSURANCE—AGENTS—REPRESENTATION OF INSURER
AND INSURED.**

This case is controlled by the decision in Ramspeck vs. Pattillo, 104 Ga. 772, 30 S. E. 962, 42 L. R. A. 197, 69 Am. St. Rep. 197, where it was held that an agent representing a fire insurance company, authorized to contract for insurance in its behalf, cannot, without the company's consent, become in his individual character the agent of a property owner who desires to obtain insurance in such company, for the reason that an agreement to act as agent for both parties in such a transaction would be an undertaking to perform inconsistent duties, and a mutual agency of this kind requires the consent of both parties. Phoenix Ins. Co. vs. Hamilton, 110 Ga. 14, 35, S. E. 305; Sessions vs. Payne, 113 Ga. 956, 39 S. E. 325.

(For other cases, see Insurance, Cent. Dig. § 127; Dec. Dig. § 98.)

* Decision rendered, May 15, 1916. 88 S. E. Rep. 967. Syllabus by the Court.

2. INSURANCE—AGENTS—REPRESENTATION OF INSURER AND INSURED.

The contention that the facts in the present case differentiate it from those just cited was not well taken. Here it was alleged that the agent represented a number of insurance companies, and had authority to accept applications on behalf of such companies and to issue policies of insurance; that the plaintiff had been accustomed for several years to insure his residence by merely telling the defendant that he wished so much insurance upon it, and the defendant would agree to issue it, and in most instances the plaintiff would never see the policy but would pay the premium due when the defendant would send him a statement thereof, and that this was the custom with a large proportion of the people dealing with the defendant; that on a certain day the plaintiff informed the defendant that he wanted to procure with him insurance to a certain amount in some fire insurance company represented by the defendant, upon a barn and its contents, and the defendant stated that he would examine the rates of the different companies represented by him, on this class of property, and would issue to the plaintiff a policy that day in the sum stated upon the property mentioned; that he did not do this, and about a month thereafter the barn was burned without being insured. Under these allegations the agent owed to his company certain duties as to issuing or not issuing a policy upon the property described, and to make him the agent of the intended insured, so as to bind him to obtain a policy in one of the companies represented by him, would be to impose upon him a dual agency with conflicting duties to his two principals, which could not be done without the knowledge or consent of the insurance company from which the policy was to be obtained.

(For other cases, see *Insurance, Cent. Dig.* § 126; *Dec. Dig.* § 96.)

3. INSURANCE—AGENTS—REPRESENTING INSURER AND INSURED.

If the plaintiff's allegations were sufficient to set out a contract between him as an owner of the property which he desired to have insured, and the agent representing several fire insurance companies and having authority to act for them, in one of which the plaintiff desired to have the property insured so as to make the agent of such company or companies, representing them in the effecting of insurance, also the agent of the property owner for the purpose of obtaining the insurance from one of such companies, and that without the knowledge or consent of the company to be affected, such contract, being contrary to public policy, did not create a duty on the part of the insurance agent to procure insurance in such company for the plaintiff, or render him liable in damages for a failure to do so.

(For other cases, see *Insurance, Cent. Dig.* § 127; *Dec. Dig.* § 98.)

Error from Superior Court, Whitfield County; A. W. Fite, Judge.
Action by W. A. Manis, administrator, against F. S. Pruden. Judgment for plaintiff, and defendant brings error. Affirmed.

George G. Glenn and M. C. Tarver, both of Dalton, for Plaintiff in Error.

W. C. Martin, of Dalton, for Defendant in Error.

OHIO FARMERS' INS. CO. vs. WILLIAMS. (9028.)*

(Appellate Court of Indiana, Division No. 2.)

1. INSURANCE—FIRE INSURANCE—STIPULATION AGAINST OTHER INSURANCE—VALIDITY.

Stipulations in policy of fire insurance that the policy shall be void if the insured has or procures any other contract of insurance are valid and reasonable, and, when they are violated, the insurer, when a loss occurs, may defend on the ground of breach of contract.

(For other cases, see Insurance, Cent. Dig. §§ 660-669; Dec. Dig. §§ 288[1], 336[1].)

2. INSURANCE—FIRE INSURANCE—STIPULATION AGAINST OTHER INSURANCE—VOIDABLE CHARACTER OF POLICY.

A stipulation in a policy of fire insurance against procuring other insurance does not render the policy void for its breach but merely voidable, at the election of the insurer.

(For other cases, see Insurance, Cent. Dig. § 856; Dec. Dig. § 336[1].)

3. INSURANCE—BREACH OF POLICY—FORFEITURE—RETURN OF PREMIUM.

Where the insurer's defense is based upon a breach of the policy of fire or life insurance that rendered the contract ineffectual from its inception, so that no risk attached, the insurer, upon learning of the breach, should seasonably offer to restore the premium received, and, failing to do so, cannot insist upon a forfeiture of the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1044, 1045; Dec. Dig. § 392[11].)

4. INSURANCE—AVOIDANCE OF LIABILITY—RETURN OF PREMIUM.

Where the insurer's liability attaches upon execution of a policy, the return of the premium is not essential to the avoidance of liability thereon for insured's breach of a stipulation.

(For other cases, see Insurance, Cent. Dig. §§ 1044, 1045; Dec. Dig. § 392[11].)

5. INSURANCE—FIRE INSURANCE—RETURN OF PREMIUM—“CANCELLATION.”

The action of a fire insurance company in denying liability on a policy because insured had effected other insurance, contrary to his stipulation, was not a “cancellation” of the policy, calling for a return of the pro rata share of the premium under its terms.

(For other cases, see Insurance, Cent. Dig. § 504; Dec. Dig. § 232.)

(For other definitions, see Words and Phrases, First and Second Series, Cancellation.)

6. INSURANCE—FIRE INSURANCE—CONSTRUCTION OF CONTRACT.

Contracts of fire insurance are strictly construed as against the insurer to prevent forfeiture, and to be construed in favor of the insured to effect the contract's end—that of indemnity in case of loss.

(For other cases, see Insurance, Cent. Dig. § 295; Dec. Dig. § 146[3].)

* Decision rendered, May 10, 1916. 112 N. E. Rep. 556.

7. INSURANCE—ACTION ON POLICY—PLEADING.

In an action on a policy of fire insurance, where the defense of forfeiture by procuring other insurance, interposed by the answer, was waived by the insurer, a reply setting up such waiver properly presents the same.

(For other cases, see Insurance, Cent. Dig. § 1628; Dec. Dig. § 641[2].)

Appeal from Circuit Court, Bartholomew County; Hugh Wickens, Judge.

Action by Samuel Hamer Williams against the Ohio Farmers' Insurance Company. From a judgment for plaintiff, defendant appeals. Judgment reversed, with instructions, and for further proceedings consistent with the opinion.

C. J. Kollmeyer and Julian Sharpnack, both of Columbus, for Appellant.

Charles S. Baker and Frank N. Richman, both of Columbus, for Appellee.



**DODGE vs. GRAIN SHIPPERS' MUT. FIRE INS. ASS'N
(No. 29886.)***

(Supreme Court of Iowa.)

1. INSURANCE—ACTIONS—EVIDENCE—SUFFICIENCY—INSURABLE INTEREST.

In an action upon a \$1,000 policy by the holder of a \$9,000 mortgage on the insured property, evidence held to show that the property, although encumbered by \$30,000 prior mortgage, was worth \$60,000, so that plaintiff had an insurable interest in the property exceeding the amount of the policy.

(For other cases, see Insurance, Cent. Dig. § 148; Dec. Dig. § 115[5].)

4. INSURANCE—ACTIONS—EVIDENCE—POWERS OF AGENT.

In an action upon an insurance policy, evidence held to show that interrelated companies acted for an insurance company in issuing such policy and collecting premiums thereon, and that they came within the terms of Code 1897, § 1750, giving to agents soliciting insurance and issuing policies power to bind the company.

(For other cases, see Insurance, Cent. Dig. § 101; Dec. Dig. § 76.)

5. INSURANCE—MISDESCRIPTION—BY AGENT.

Where a policy written and issued by an agent with power to represent the company does not correctly describe the insured property and insured has not concealed or misrepresented any fact, the misdescription does not render the policy void.

(For other cases, see Insurance, Cent. Dig. § 589; Dec. Dig. § 274.)

6. INSURANCE—ESTOPPEL—BUILDER'S RISK.

Although a building partially completed was boarded up and vacant for several months before and after being insured so as not to be considered a "builder's risk" at the home office of an insurance com-

* Décision rendered, May 13, 1916. 157 N. W. Rep. 955.

pany, yet, if the insurance company's local agents in another state insured it as a "builder's risk," and the parties to the contract so understood it, the company, when sued upon the policy, cannot claim it was not correctly described.

(For other cases, see Insurance, Cent. Dig. §§ 968, 975-997; Dec. Dig. § 378[1].)

7. INSURANCE—ESTOPPEL—ISSUANCE OF POLICY WITHOUT OBJECTION TO PARTIES EXISTING.

Where an insurance company knows that a property is not being operated at the time the policy is issued and is vacant, it cannot claim that the policy was avoided by such vacancy in violation of its terms.

(For other cases, see Insurance, Cent. Dig. §§ 942, 966, 967, 975-997; Dec. Dig. § 377[1].)

8. INSURANCE—CONSTRUCTION—INTENTION OF PARTIES.

A policy should not be so construed as to defeat the obvious intention of the parties.

(For other cases, see Insurance, Cent. Dig. §§ 292, 296, 297; Dec. Dig. § 146[1].)

9. INSURANCE—CONSTRUCTION—INTENTION OF PARTIES.

The intention is to be obtained first from the language of the entire policy in connection with the risk or subject-matter.

(For other cases, see Insurance, Cent. Dig. § 294; Dec. Dig. § 146[2].)

10. INSURANCE—FORFEITURE—CHANGE OF TITLE—LITIGATION—"KNOWLEDGE."

Under a provision that the policy should become void if with knowledge of insured foreclosure proceedings be commenced, the policy is not avoided by the commencement of foreclosure proceedings on a claim for a mechanic's lien having no legal basis and as to which insured had only constructive notice, as the word "knowledge" is distinguished from constructive notice.

(For other cases, see Insurance, Cent. Dig. §§ 815-817; Dec. Dig. § 328[14].)

Appeal from District Court, Ida County; M. E. Hutchinson, Judge.

Action to recover amount alleged to be due upon a policy of insurance. Policy issued to insure plaintiff's interest as mortgagee in the property insured. Cause tried to the court without a jury. Judgment for the defendant, dismissing plaintiff's petition. Plaintiff appeals. Reversed.

McWhinney & Brown, of Toronto, Ontario, Canada, Miller & Wallingford and Roy E. Curry, all of Des Moines, and Charles S. Macomber, of Ida Grove, for Appellant.

Johnston Bros., of Ida Grove, for Appellee.

MURPHY vs. CONTINENTAL INS. CO. (No. 30712.)*
 (Supreme Court of Iowa.)

1. INSURANCE—REPRESENTATIONS OF AGENT.

An insurance company is not bound by a mere soliciting insurance agent's representations or statement as to the legal effect in the policy of words describing the property covered.

(For other cases, see Insurance, Cent. Dig. §§ 180-182, 1849, 1850; Dec. Dig. § 129.)

2. INSURANCE—PROPERTY COVERED—"HAY IN STACK."

A stack of hay, grain, straw, or the like is a large quantity thereof collected and usually built up in layers in conical, oblong, or rectangular form to a point or ridge at the top so that it will be preserved against the inclemencies of the weather, and a policy covering "hay in stack" does not cover hay in the mow of a barn.

(For other cases, see Insurance, Cent. Dig. § 351; Dec. Dig. § 165.)

(For other definitions, see Words and Phrases, First and Second Series, Stack.)

3. INSURANCE—PROPERTY COVERED—"FARM UTENSIL"—"GARDEN TOOLS."

The term "farm utensils" in an insurance policy is broader than the term "garden tools" therein, and includes any instrumentalities within the meaning of the word "utensils" made use of on a farm, including a stock scale or a new windmill not erected.

(For other cases, see Insurance, Cent. Dig. §§ 342, 344; Dec. Dig. § 163[3].)

Appeal from District Court, Iowa County; R. P. Howell, Judge.

Action for indemnity on an insurance policy resulted in a directed verdict for defendant and judgment thereon. The plaintiff appeals. Reversed.

W. E. Wallace, of Williamsburg, for Appellant.
 Stapleton & Stapleton, of Marengo, for Appellee.

* Decision rendered, May 10, 1916. 157 N. W. Rep. 855.



CLAY, INSURANCE COM'R, vs. DIXIE FIRE INS. CO.*
 (Court of Appeals of Kentucky.)

1. INSURANCE—TAXATION OF INSURANCE COMPANIES—CONSTRUCTION OF STATUTE.

Ky. St. § 637, imposing upon foreign insurance companies the same license tax which shall be imposed by the laws of their domicile on Kentucky insurance companies doing business in the state of such insurer's domicile, applies to a foreign insurance company, where the

* Decision rendered, March 22, 1916. 183 S. W. Rep. 529.

laws of its domicile impose taxes on foreign insurance companies, which taxes would have to be paid by any Kentucky company doing business therein, though no Kentucky company was doing business in the domiciliary state of the foreign insurer; it appearing that there were companies in existence qualified to do business in such state.

(For other cases, see Insurance, Cent. Dig. §§ 16, 18-22; Dec. Dig. § 20.)

2. INSURANCE—LICENSE TAX—INJUNCTION—BURDEN OF PROOF.

An insurance company, seeking to enjoin the Insurance Commissioner from levying taxes on the ground that a statute was not applicable to it, has the burden of proof.

(For other cases, see Insurance, Cent. Dig. § 33; Dec. Dig. § 26.)

Appeal from Circuit Court, Franklin County.
On petition for rehearing. Petition overruled.
For former opinion, see 181 S. W. 1123.

Jas. Garnett, Atty. Gen., and Chas. H. Morris, Asst. Atty. Gen., for Appellant.

Lewis Apperson, of Mt. Sterling, for Appellee.



AETNA INS. CO. vs. COWAN, COUNTY TREASURER.
(No. 17891.)*

(Supreme Court of Mississippi, Division B.)

2. INSURANCE—RIGHTS OF PARTIES—ARBITRATION—WAIVER.

Where the insurer, under a policy containing a loss payable clause in favor of the county treasurer, attempted to arbitrate the loss as permitted by the policy, but failed to include the treasurer in such arbitration, the insurer did not waive its right to an arbitration with the treasurer.

(For other cases, see Insurance, Cent. Dig. § 1436; Dec. Dig. § 576[1].)

3. INSURANCE—RIGHTS OF PARTIES—LOSS PAYABLE CLAUSES—EFFECT—INDEPENDENT CONTRACT.

A loss payable clause in a policy of fire insurance, to the effect that "any loss proved due the assured shall be held payable to the county treasurer, as his interest may appear," does not create a new contract with the treasurer, independent of the liability to the assured, though by Code 1906, § 2596, certain provisions peculiar to the mortgagee are written into every insurance contract by operation of law.

(For other cases, see Insurance, Cent. Dig. §§ 1444-1447; Dec. Dig. § 581.)

Appeal from Circuit Court, Jackson County; J. L. Ballenger, Judge.
Action by R. W. Cowan, Treasurer of Jackson County, against the Aetna Insurance Company. From a judgment for plaintiff on peremptory

* Decision rendered, May 15, 1916. 71 South. Rep. 746.

instruction, on sustaining his demurrers to defendant's pleas, defendant appeals. Reversed and remanded.

McLaurin & Armistead, of Vicksburg, for Appellant.
W. M. Denny, of Pascagoula, for Appellee.

HOME MUT. FIRE INS. CO. vs. PITTMAN. (No. 17856.)*
(Supreme Court of Mississippi, Division B.)

3. INSURANCE—FIRE INSURANCE—CONSTRUCTION OF POLICY.

Where a policy of fire insurance provided that if the interest of insured in the property was or should become other or less than perfect, legal and equitable title, except as stated in writing the contract should be void and that, in case the interest of insured was not sole ownership, the company should not be liable by virtue of the contract for any sum exceeding the actual cash value of insured's interest, such second clause related to the situation where the ownership was less than legal and equitable title, and the fact had been noted on the policy in writing.

(For other cases, see Insurance, Cent. Dig. §§ 347-350; Dec. Dig. § 164[1].)

4. INSURANCE—FIRE INSURANCE—FORFEITURE—LACK OF TITLE.

Where fire insurance was taken out by plaintiff, who was not the owner of property, but a tenant of his wife, the house burned being situated on her land, the policy, providing that it should be void unless insured had perfect legal and equitable title, was forfeited.

(For other cases, see Insurance, Cent. Dig. §§ 602, 635; Dec. Dig. § 282[1].)

5. INSURANCE—FIRE INSURANCE—FAILURE TO READ POLICY.

The holder of a policy of fire insurance, who had possession thereof for a long time before loss, was bound by its terms, though he did not read it.

(For other cases, see Insurance, Cent. Dig. § 262; Dec. Dig. § 141[4].)

Appeal from Circuit Court, Yalobusha County; J. B. Eckles, Judge. Suit by N. A. Pittman against the Home Mutual Fire Insurance Company. From a judgment for plaintiff, defendant appeals. Case reversed, and suit dismissed.

McLaurin & Armistead and T. G. Birchett, all of Vicksburg, for Appellant.

Creekmore & Stone, of Coffeeville, for Appellee.

* Decision rendered May 15, 1916. 71 So. Rep. 739.

**BROWN vs. CONNECTICUT FIRE INS. CO. OF HARTFORD,
CONN. (No. 14091.)***
(St. Louis Court of Appeals. Missouri.)

2. INSURANCE—AMOUNT OF DAMAGE TO PROPERTY.

In an action on a policy of a fire insurance the question of total or partial loss is to be ascertained by reference to the present condition of the building, and whether it has lost its identity and specific character as a building rather than the use to which it might be put after being repaired.

(For other cases, see Insurance, Cent. Dig. §§ 1266-1268; Dec. Dig. § 493.)

Appeal from Circuit Court, St. Louis County; G. A. Wurdeman, Judge.

"Not to be officially published."

Suit by Rachel Brown against the Connecticut Fire Insurance Company of Hartford, Conn. From an order setting aside judgment for plaintiff and granting a new trial, plaintiff appeals. Reversed and remanded.

A. E. L. Gardner and R. H. Stevens, both of Clayton, and Chas. E. Morrow and Geo. E. Booth, both of St. Louis, for Appellant.

Bernard Greensfelder, of St. Louis, and Bates, Harding, Edgerton & Bates, of Chicago, Ill., for Respondent.

* Decision rendered, March 7, 1916. Rehearing denied, March 28, 1916.
184 S. W. Rep. 122.



**GOLD ISSUE MIN. & MILL. CO. vs. PENNSYLVANIA
FIRE INS. CO. OF PHILADELPHIA. (No. 17298.)***
(Supreme Court of Missouri.)

**1. INSURANCE—FOREIGN INSURANCE COMPANIES—ACTIONS
—SERVICE OF PROCESS.**

Rev. St. 1909, § 7042, provides that any foreign insurance company desiring to transact business in the state shall first file with the superintendent of the insurance department a written instrument or power of attorney, appointing and authorizing him to acknowledge or receive service of process from any court and upon whom such process may be served in behalf of the company, and consenting that service of process upon him shall be held to be as valid as if served upon the company, and that such service shall be valid and deemed personal service upon the company so long as it shall have any policies or liabilities outstanding in the state. Held, that this authorizes service of process upon the superintendent in an action against a foreign

* Decision rendered, March 24, 1916. Rehearing denied, April 10, 1916.
184 S. W. Rep. 999.

insurance company doing business in the state and having complied therewith, upon a contract of insurance made outside the state and covering property outside the state.

(For other cases, see Insurance, Cent. Dig. § 1573; Dec. Dig. § 627[2].)

3. INSURANCE—FOREIGN CORPORATIONS—SERVICE OF PROCESS—CONSTITUTIONAL AND STATUTORY PROVISIONS.

Rev. St. 1909, § 7042, requiring foreign insurance companies doing business in the state to file an instrument authorizing the service of process on the superintendent of the insurance department, construed as applying to actions on contracts made outside the state, is not unconstitutional on the theory that the Legislature had no constitutional power to confer jurisdiction upon the court to try and determine suits against foreign insurance companies licensed and doing business in the state, based upon contracts of insurance executed outside the state.

(For other cases, see Insurance, Dec. Dig. § 610.)

4. INSURANCE—FOREIGN CORPORATIONS—SERVICE OF PROCESS—CONSTITUTIONAL AND STATUTORY PROVISIONS.

Rev. St. 1909, § 7042, is not unconstitutional, as authorizing service of process on the superintendent of the insurance department in suits against foreign insurance companies doing business in the state without authority, based upon policies of insurance issued in another state, it being expressly limited in its application to foreign insurance companies doing business in the state under authority from the state duly granted to them, and not applying to such companies doing business without authority.

(For other cases, see Insurance, Dec. Dig. § 610.)

5. INSURANCE—ACTIONS ON POLICIES—CONVERSATIONS WITH AGENTS.

In an action on an insurance policy covering a smelter and providing that the property should not be idle for more than thirty days without defendant's written permission, and also prohibiting incumbrances upon the property, it appeared that the property was shut down, and that a mortgage was executed, but subsequently paid before the fire. Evidence was admitted that when the policy was issued plaintiff informed defendant's general agents through whom the policy was issued that the smelter might be idle at times for more than thirty days, and asked what he should do, and was told by the agents that this would be all right; that after the issuance of the policies the same inquiry was made and answered in the same way; that when it was found that the business would have to be shut down, the agents were told thereof, and said it would be all right, and that subsequently they were notified that the mill was idle, and asked what should be done and made no objections thereto; and that they were told of the mortgage and made no objection. *Held*, that the admission of the evidence as to the conversations with the agents, prior to and at the time the policy was issued and subsequently respecting the incumbrances upon the property and the vacancy of the property, was not error.

(For other cases, see Insurance, Cent. Dig. §§ 1555, 1687, 1688, 1699; Dec. Dig. § 664.)

In Banc. Appeal from Circuit Court, Audrain County; James D. Barnett, Judge.

Action by the Gold Issue Mining & Milling Company against the Pennsylvania Fire Insurance Company of Philadelphia. Judgment for plaintiff, and defendant appeals. Affirmed.

David H. Robertson, of Mexico, Mo., and Fred Herrington and Lewis & Grant, all of Denver, Colo., for Appellant.

Fauntleroy, Cullen & Hay, of St. Louis, Fry & Rodgers, of Mexico, Mo., and Fred D. Shaw, for Respondent.

Percy Werner, of St. Louis, and Sutton & Huston, of Troy, amici curiae.



MILLARD ET AL. VS. BEAUMONT ET AL. (No. 1776.)*

(Springfield Court of Appeals. Missouri.)

2. INSURANCE—FIRE INSURANCE—PERSONS SECURED.

A fire insurance contract is a purely indemnity contract in favor of the insured only, not running with the land, and, in the absence of some special provision to the contrary, the loss recovered must be a loss to the person insured, excluding any loss after the insured's death, or after he has parted with his title and interest in the property.

(For other cases, see Insurance, Cent. Dig. §§ 1439, 1440, 1442, 1443; Dec. Dig. § 580[1].)

3. INSURANCE—LOSS PAYMENT CLAUSE—CONSTRUCTION.

Where a house, household furniture, etc., were insured in favor of an owner, who by will devised a vested life estate to her nephew with remainder to his bodily heirs, and the nephew procured the insurer to add a clause to the policy, making the loss payable to him as his interest might appear, and after the death of the insured, but during the life of the policy, the property was destroyed by fire, there was no new contract entered into with the life tenant for his personal indemnity against loss. He having paid no premium, and the policy having been continued on the premium previously paid, the loss payment clause merely perpetuated the policy in favor of the successors to the title of the property insured.

(For other cases, see Insurance, Cent. Dig. §§ 1448-1451, 1453, 1454, 1485; Dec. Dig. § 582.)

Appeal from Circuit Court, Texas County; L. B. Woodside, Judge.
Suit by Homer S. Millard and others against Charles M. Beaumont, executor of the estate of E. M. Millard, and others, to determine the interests of plaintiffs and defendants in the proceeds of a fire insurance policy. From the judgment rendered plaintiffs appeal. Reversed and remanded, with directions.

Barton & Impey, of Houston, for Appellants.
Lamar, Lamar & Lamar, of Houston, for Respondents.

* Decision rendered, April 15, 1916. Rehearing denied, May 9, 1916. 185
S. W. Rep. 547.

STUYVESANT INS. CO. vs. REID ET AL. (No. 453.)*

(Supreme Court of North Carolina.)

1. INSURANCE—INTEREST OF MORTGAGEE.

Since a mortgagee and mortgagor can each insure mortgaged property for his own benefit, where a mortgagee insures at his own expense without stipulations in favor of the mortgagor or conditions imposing an obligation and duty on the mortgagee to protect the property for the mortgagor's benefit, the mortgagee, in case of loss or damage by fire, is not accountable to the mortgagor for the insurance collected either on the debt or otherwise.

(For other cases, see Insurance, Cent. Dig. §§ 1444-1447; Dec. Dig. § 581.)

2. INSURANCE—INTEREST OF MORTGAGEE—SUBROGATION.

Where a mortgagee has insured the mortgaged property for his own benefit, paying the premiums himself and without agreement with the mortgagor or stipulation or conditions imposing a duty to protect the mortgagor's interest, the insurance company, in case of loss, on payment of the policy and satisfaction of the debt, is entitled to be subrogated to the rights of the mortgagee.

(For other cases, see Insurance, Cent. Dig. §§ 1509, 1515, 1516; Dec. Dig. § 606[2].)

3. INSURANCE—PARTIES TO THE CONTRACT—RELATION—MORTGAGOR AND MORTGAGEE.

Where defendant purchased a piano on the installment plan, and by the terms of the general policy of insurance carried by the seller covering all of its pianos the insurance was extended to cover pianos sold in this way, the relationship became, in effect, that of mortgagor and mortgagee, and the rights and liabilities of the purchaser with reference to the insurance money must be determined by the principles applicable to that relationship; the question depending upon the intent of the parties and the nature of the obligations assumed.

(For other cases, see Insurance, Cent. Dig. §§ 1444-1447; Dec. Dig. § 581.)

4. INSURANCE—INSURABLE INTEREST—INTEREST OF MORTGAGEE.

In the absence of some arrangement with the mortgagor or some obligation growing out of the relationship between them, the mortgagee could only insure mortgaged property to the extent of its interest.

(For other cases, see Insurance, Cent. Dig. § 148; Dec. Dig. § 115[5].)

5. INSURANCE—INTEREST OF MORTGAGEE—SUBROGATION.

Where the defendant purchased a piano on the installment plan and assumed the risk in case of fire, the relation being that of mortgagor and mortgagee, under a general policy of insurance carried by the seller to insure their interest in pianos sold in this way, in which policy the defendant had no interest, the defendant has no claim to the insurance money and no protection from the plaintiff's right of subrogation by reason of its payment to the seller under the general policy.

(For other cases, see Insurance, Cent. Dig. §§ 1509, 1515, 1516; Dec. Dig. § 606[2].)

* Decision rendered, May 10, 1916. 88 S. E. Rep. 779.

Appeal from Superior Court, Gaston County; Justice, Judge.
Action by the Stuyvesant Insurance Company against J. P. Reid and
others. Judgment for the defendants, and plaintiff appeals. Reversed.

C. W. Tillett, Jr., of Charlotte, for Appellant.
Mangum & Woltz, of Gastonia, for Appellees.

HARTFORD FIRE INS. CO. vs. MATHIS. (No. 6723.)*
(Supreme Court of Oklahoma.)

1. INSURANCE—ACTIONS—ISSUES AND PROOF.

Where a cause of action is instituted upon a contract of insurance and it is claimed in the petition that proof of loss was furnished to the company as provided by the contract, evidence is improperly received, where it is objected to, seeking to establish a waiver or estoppel.

(For other cases, see Insurance, Cent. Dig. §§ 1554, 1634-1641; Dec. Dig. § 645[3]; Pleading, Cent. Dig. § 1330.)

2. INSURANCE—ACTIONS—PLEADING—WAIVER.

A waiver should be pleaded by the one relying thereon.

(For other cases, see Insurance, Cent. Dig. §§ 1603-1605; Dec. Dig. § 634[2].)

Commissioners' Opinion, Division No. 3. Error from District Court, Majors County; Jas. W. Steen, Judge.

Action by L. Mathis against the Hartford Fire Insurance Company. Judgment for plaintiff, and defendant brings error. Reversed and remanded.

Scothorn, Caldwell & McRill, of Oklahoma City, for Plaintiff in Error.

Jno. V. Roberts, of Fairview, and J. J. Hughes, of Ames, for Defendant in Error.

* Decision rendered, April 18, 1916. 157 Pac. Rep. 134. Syllabus by the Court.

HOME INS. CO. OF NEW YORK vs. MOBLEY ET AL.
(No. 6339.)*

(Supreme Court of Oklahoma.)

1. INSURANCE—AGENTS—AUTHORITY.

Where a policy of fire insurance entered into by a foreign corporation is not valid until countersigned by the local agent, such agent will be held to be the officer having power to issue the same in view of

* Decision rendered, April 5, 1916. Rehearing denied, May 16, 1916. 157 Pac. Rep. 324. Syllabus by the Court.

section 3434, Rev. Laws 1910, even though the policy contained a provision providing that it should "not be valid until countersigned by the secretary or assistant secretary of the Western Farm Department at Chicago, Illinois."

(For other cases, see Insurance, Cent. Dig. §§ 105, 500; Dec. Dig. § 80.)

2. INSURANCE—FORFEITURE—WAIVER.

Where an insurance company reinstates a policy which has been canceled, after knowledge of a breach of the policy prior to said reinstatement has been brought home to the local issuing agent, *held*, that the forfeiture is waived.

(For other cases, see Insurance, Cent. Dig. § 969; Dec. Dig. § 378[3].)

Commissioners' Opinion, Division No. 2. Appeal from District Court, Carter County; Stillwell H. Russell, Judge.

Action by Tennie Mobley and another against the Home Insurance Company of New York on a fire insurance policy. Judgment for plaintiff, and defendants appeal. Affirmed.

Burwell, Crockett & Johnson, of Oklahoma City, for Plaintiff in Error.

Johnson & McGill, of Ardmore, for Defendants in Error.



DE ROSSETT HAT CO. *vs.* LONDON LANCASHIRE FIRE INS. CO. ET AL.*

(Supreme Court of Tennessee.)

2. INSURANCE—ACTION ON POLICY—ISSUES.

In an action on fire policies, where the insurers admitted liability, paying into the court the amounts of the policies and withdrawing their answers denying liability, so that the only thing left for trial was whether complainant was entitled to the statutory penalty for failure to pay within sixty days after demand, issues as to whether the fire was accidental are immaterial and are not to be submitted.

(For other cases, see Insurance, Cent. Dig. §§ 1554, 1632-1644; Dec. Dig. § 645.)

5. INSURANCE—FIRE INSURANCE—PENALTIES.

Under Acts, 1901, c. 141, providing a 25 per cent penalty if an insurance company refuse to pay a fire loss within sixty days after demand shall have been made by the holder of the policy on which the loss occurred, a formal demand on the insurer after maturity of the policy is fixed according to its terms is necessary to entitle the insured to the penalty.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

* Decision rendered, Feb. 21, 1916. 183 S. W. Rep. 720.

6. INSURANCE—FIRE INSURANCE—STATUTES.

Acts 1901, c. 141, providing a penalty of 25 per cent for nonpayment of a fire loss within sixty days after demand, being a penal statute, must be strictly construed.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

7. INSURANCE—FIRE INSURANCE—CONTRACTS — MODIFICATION.

An insurance contract, like any other contract, may be modified after it is made by express agreement of the parties.

(For other cases, see Insurance, Cent. Dig. §§ 273-275; Dec. Dig. § 144.)

8. INSURANCE—FIRE POLICIES—PENALTY.

Fire occasioning a loss occurred on September 25, 1913. Proofs of loss were mailed November 1st of that year, the only demand for payment was by letter dated and mailed December 18th, and the original bills of complaint were filed on the 7th of the following January. The policies provided that loss should be payable sixty days after satisfactory proof of loss had been received by the insurers. Acts 1901, c. 141, provides a penalty of 25 per cent in case an insurer fails within sixty days after demand to pay the amount due. *Held*, that the insured was not entitled to the penalty; suit having been begun a few days after the policy matured, and payment within sixty days after demand after maturity not having been refused.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

10. INSURANCE—FIRE INSURANCE—AGREEMENTS.

Where insured and insurers executed a nonwaiver agreement, a statement, made by insured's adjuster and assented to by those of the insurers, that such agreement would not delay payment of claims for fire loss more than five days at the utmost, does not show insured was entitled to payment within such time and furnish basis for recovery of the 25 per cent penalty provided for by Acts 1901, c. 141, in case of refusal of payment within sixty days after demand, where the policies did not require payment until sixty days after furnishing of proofs of loss.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

Certiorari to Court of Civil Appeals.

Bills by the De Rossett Hat Company against the London & Lancashire Fire Insurance Company and others, which were consolidated. From a decree for complainant, defendants appealed to the Court of Civil Appeals, and, the decree being there affirmed, they bring certiorari. Judgments reversed, and bills dismissed.

W. B. Miller and Thomas & Thomas, all of Chattanooga, for Plaintiff. Sizer, Chambliss & Chambliss, of Chattanooga, for Defendants.

McPHERSON vs. CAMDEN FIRE INS. CO. (974.)*.

(Court of Civil Appeals of Texas. Amarillo.)

2. INSURANCE—WARRANTIES—BREACH.

The breach of mere technical or immaterial provision in an insurance policy which does not contribute to the loss will not defeat or forfeit a right under the policy.

(For other cases, see Insurance, Cent. Dig. §§ 700, 701; Dec. Dig. § 308.)

3. INSURANCE—AVOIDANCE OF POLICY—STATUTE—CONSTITUTIONALITY.

Acts 33d Leg. c. 105 (Vernon's Sayles's Ann. Civ. St. 1914, arts. 4874a, 4874b), providing that any breach or violation by the insured of any of the warranties, conditions, or provisions of a policy of fire insurance shall not render the policy void or constitute a defense for loss unless such breach or violation contributed to bring about the destruction, is constitutional.

(For other cases, see Insurance, Cent. Dig. § 539; Dec. Dig. §§ 250[1], 302.)

4. INSURANCE—WARRANTIES—BREACH—IRON SAFE CLAUSE.

Acts 33d Leg. c. 105, § 1 (Vernon's Sayles's Ann. Civ. St. 1914, art. 4874a), providing that no breach or violation by the insured of any of the warranties, conditions, or provisions shall render void the policy or constitute a defense for loss unless such breach or violation contributed to bring about the destruction, refers to those warranties to be performed before the fire, and a breach of which might contribute to the loss and did not, and does not apply to warranties requiring the insured to keep books and accounts and deliver them to the company for examination after the fire, which breach could not contribute to or occur until after the loss.

(For other cases, see Insurance, Cent. Dig. § 853; Dec. Dig. § 335[3].)

Appeal from District Court, Dallas County; Kenneth Foree, Judge. Suit by Electra McPherson against the Camden Fire Insurance Company. Judgment for the defendant, and plaintiff appeals. Affirmed.

Seay & Seay, of Dallas, for Appellant.
Thompson, Knight, Baker & Harris and Will C. Thompson, all of Dallas, for Appellee.

* Decision rendered, May 3, 1916. On motion for rehearing, May 17, 1916. 185 S. W. Rep. 1055.

SPRINGFIELD FIRE & MARINE INS. CO. vs. NELMS

ET AL. (No. 8317.)*

(Court of Civil Appeals of Texas. Ft. Worth.)

INSURANCE—FIRE INSURANCE—IMMATERIAL BREACH OF POLICY—STATUTE.

Under Act April 2, 1913 (Acts 33d Leg. c. 105, entitled "An act to prevent fire insurance companies from avoiding liability for loss * * * to personal property under technical and immaterial provisions of the policy * * * where the act breaching such provision has not contributed to bring about the loss, * * *") § 1 (Vernon's Sayles's Ann. Civ. St. 1914, art. 4874a), and section 3, an insurer of personality against fire could not escape liability for a loss for insured's failure to comply with a special provision of the policy that he would, as part of his proofs of loss, if requested, furnish a certificate of the magistrate or notary public living nearest the place of fire, stating that he had examined the circumstances and believed the insured honestly sustained loss, where the fact of loss was undisputed, the amount not contested, and notice and proofs made, while the insurer's pleadings and evidence contained no suggestion that the fire wrongfully originated by act or procurement of the insured.

(For other cases, see Insurance, Cent Dig. §§ 1350, 1351; Dec. Dig. § 546.)

Error from Erath County Court.

Suit by Nat Nelms and others against the Springfield Fire & Marine Insurance Company. To review a judgment for plaintiffs, defendant brings error. Affirmed.

Thompson, Knight, Baker & Harris and W. C. Thompson, all of Dallas, for Plaintiff in Error.

Hickman & Bateman, of Dublin, for Defendants in Error.

* Decision rendered, Feb. 5, 1916. Rehearing denied, March 18, 1916.
184 S. W. Rep. 1094.



COMMONWEALTH INS. CO. OF NEW YORK vs. FINEGOLD.

(No. 7043.)*

(Court of Civil Appeals of Texas. Galveston.)

5. INSURANCE—FIRE INSURANCE—IMMATERIAL BREACH OF POLICY—STATUTE.

Under Acts 33d Leg. c. 105 (Vernon's Sayles's Ann. Civ. St. 1914, arts. 4874a, 4874b) providing that no breach by the insured of any of the provisions of any fire insurance policy upon personality shall render void the policy or constitute a defense to a suit for loss unless such breach contributed to bring about the destruction of the property, a

* Decision rendered, Jan. 19, 1916. Rehearing denied, Feb. 10, 1916. 183
S. W. Rep. 833.

policy of fire insurance on personality, providing that the keeping of gasoline on the premises should avoid the policy, and that an act increasing the hazard by means in the control of knowledge of the insured should do so likewise, was not avoided, and insured's recovery thereon was not prevented, by his keeping gasoline on the premises where such breach did not contribute to bring about the destruction of the property.

(For other cases, see Insurance, Cent. Dig. §§ 842-846; Dec. Dig. § 333.)

6. INSURANCE—FIRE INSURANCE—BREACH OF POLICY—STATUTE.

Such provision has no application to permit the insured, who has broken the stipulation of his policy insuring his stock of goods that he should keep books, etc., in an iron fireproof safe, to recover on the policy, although the failure to keep the books did not contribute to bring about the destruction of the property, since the statute was passed to prevent insurance companies from escaping liability on the ground that insured had violated the policy only where the breach could have, but in fact did not, contribute to bring about the loss.

(For other cases, see Insurance, Cent. Dig. §§ 852, 853; Dec. Dig. § 335.)

7. INSURANCE—FIRE INSURANCE—MATERIAL BREACH OF POLICY.

Insured's failure to substantially comply with the provision of a fire insurance policy by not keeping his books in a fireproof safe will defeat his recovery on the policy; the provision being material.

(For other cases, see Insurance, Cent. Dig. §§ 842-846; Dec. Dig. § 333.)

Appeal from District Court, Harris County; Wm. Masterson, Judge.

Action by B. Finegold against the Commonwealth Insurance Company of New York. From a judgment for plaintiff, defendant appeals. Affirmed in part and reversed and rendered in part.

Dannenbaum & Taub, of Houston, for Appellant.

Atkinson, Graham & Atkinson, of Houston, for Appellee.

ACCIDENT AND HEALTH.

COURT OF APPEALS OF KENTUCKY.

PACK

vs.

PRUDENTIAL CASUALTY CO.*

1. INSURANCE—HEALTH AND ACCIDENT INSURANCE—CONDITIONS OF POLICY—INSTRUCTIONS.

Under an accident policy insuring against various accidental injuries and against death proximately resulting from a sunstroke, liability of the insurer attaches, if the sunstroke occurs while the insured is about his ordinary work, and the sunstroke need not be preceded by or caused by an accident.

(For other cases, see Insurance, Cent. Dig. § 1145; Dec. Dig. § 438.)

2. INSURANCE—ACCIDENT INSURANCE—“ACCIDENT”—SUNSTROKE.

A sunstroke received while at work in the ordinary and usual course of employment is an unexpected event not according to the usual course of things, within the meaning of the word “accident” as used in the policy insuring against accidents.

(For other cases, see Insurance, Cent. Dig. § 1162; Dec. Dig. § 449.)

(For other definitions, see Words and Phrases, First and Second Series, Accident.)

3. INSURANCE—HEALTH AND ACCIDENT INSURANCE—LIABILITY—EVIDENCE—SUFFICIENCY.

Evidence *held* insufficient to show any reasonable connection between a sunstroke July 6th and a death by pneumonia July 10th, and direction of verdict for defendant was proper.

(For other cases, see Insurance, Cent. Dig. §§ 1745, 1763, 1764; Dec. Dig. § 668[11.])

Appeal from Circuit Court, Boyd County.

Action by Julia Pack against the Prudential Casualty Company. From a judgment on directed verdict for defendant, plaintiff appeals. Affirmed.

John W. Woods and A. T. Bryson, both of Ashland, for Appellant.
Watt M. Prichard and Proctor K. Malin, both of Ashland, for Appellee.

CARROLL, J.

In March, 1913, Garfield Pack secured an accident and health insurance policy in the Prudential Casualty Company, with a death benefit of \$1,000. The beneficiary of the policy was his wife, the appellant, Julia Pack. The policy stipulated that it

* Decision rendered, May 9, 1916. 185 S. W. Rep. 496.

insured Garfield Pack "against death or loss of time on account of disability resulting directly and independently of all other causes, from bodily injuries sustained through external, violent and accidental means. * * *" And under the heading "special death indemnity" there was this clause:—

"If sunstroke, caused by the direct effect of the sun's rays, or freezing, septicæmia, or hydrophobia, or the involuntary and unconscious inhalation of gas or other poisonous vapor, accidentally suffered by the insured, shall result directly, independently and exclusively of all other causes, in the death of the insured within ninety days from date of exposure or infection, the company will pay the beneficiary hereinbefore named the principal sum of this policy, and the company shall not be liable under any other provision of this policy for death so caused."

On July 10, 1913, Garfield Pack died, as claimed by the beneficiary, from the effect of sunstroke, and thereafter the beneficiary demanded from the company the indemnity of \$1,000, and in addition \$50 to which she claimed to be entitled under other provisions of the policy. The company denied all liability, and thereupon the beneficiary brought this suit. On the trial of the case before a jury, after the evidence of both parties had been introduced, the trial court directed a verdict for the casualty company, and the beneficiary prosecuted this appeal.

There are two questions presented for our consideration: First, the proper construction of the contract of insurance; and, second, the sufficiency of the evidence to take the case to the jury.

The petition charged:—

"That on the 10th day of July, 1913, while said policy was in full force and effect, the said insured, Garfield Pack, died from the effect of sunstroke, caused by the direct effect of the sun's rays, which he had received previous thereto, to wit, on or about the 5th day of June, 1913, and independently of all other causes; the said sunstroke resulting in the said insured's death within 90 days of the time when he received said injuries. She says that the insured received the said sunstroke while he was working for the Ohio Valley Electric Railway Company, as a section hand repairing track of the said company."

A review of the evidence produced on the trial shows that on Friday morning, July 6th, while at work, Pack complained of being sick; that it was a hot day, and he looked red; that when the men went to eat their dinner under a tree Pack opened his basket but did not eat anything; that a little while after dinner they all went to work, but Pack only worked a short time and then quit; that he did not return to work until Monday; that he was a strong, healthy, fleshy man about 42 years old; that he died on July 10th of pneumonia and had been sick with diarrhea for about 10 days before he died; that when he came home on June 6th he looked red and flushed and did not eat any supper; that that

night he complained of his head hurting and of diarrhea; that on the next day he also complained of his head and vomited a time or two; that on the following Monday, June 9th, he went back to work and worked about 10 hours a day each day until June 20th, when he quit and after this went about until June 27th, when he first called in a doctor.

Dr. De Bord testified as follows:—

"Q. When were you called to see him during his last illness? A. As well as I remember, it was about the 28th of June, 1913. Q. What was his condition when you called on him at that time? A. Well, when I found him, whenever it was, he had diarrhea and cramping and a headache; complained of headache, flushed face with veins distended in his face frequently; rapid pulse. Q. How did the disease progress then from that time on until his death? Just tell the jury about it. A. Well, the first day I was up to see him it seemed that the diarrhea was hurting him worse than anything else. I think the second or third trip I saw him the diarrhea was checked. He had got better of that; he had got better of throwing up, and for about a couple of days there he got better and about, as near as I remember, the 6th of July, he developed this trouble with his heart and his lungs. Q. Go ahead and describe that. A. Well, he had—it seems that my diagnosis was that of pneumonia. It set in about the 6th of July, about four days before he died, and it ran a rapid gait. His temperature went up, and I called in Dr. Kercheval and we didn't altogether decide whether he had pneumonia. Q. Now, from the history of the case and from the symptoms you observed while treating this man, what would you say caused death? A. From the history of the case—I got a good, plain history—he had been overheated some few days before, or sunstruck, or overheated, whatever you want to call it, all the same. But his history was that he was first struck down with it, and that he got up after a while and went back to work and worked a while, and then had to lay off a few days; that he went back to work again, and every time he got in the sun he would get heated and he would begin to weaken down; couldn't stand the heat; that he tried for several days and then quit again. That is a condition of sunstroke; every time he would get in the sun he would weaken down again, and still this diarrhea kept up all the time up until after I got to treating him; and following overheating or sunstroke there is a fever that is called 'thermic fever,' which runs a course— Q. Just tell what you know about it yourself. Now, considering all the history of the case and what you found there, what would you say caused his death? A. Well, according to history, all the way we can make our judgments—the history of the case, and from what I found there, that the man was overheated in the first place, which led to this other trouble. * * * Q. What about the vomiting and diarrhea? A. Vomiting and diarrhea is things

that come after that, that follows afterwards, yes—this may not be present just at the time. Q. You mean be present at the time the person is stricken? A. Yes. Q. What about being overheated? A. Being overheated, you have headache— Q. How will a person look in the face? A. Flushed face."

On his cross-examination he testified as follows:—

"Q. When you visited him, Doctor, on the 28th of June, you found him suffering with diarrhea? A. Yes, sir. * * * Yes, he had this diarrhea or vomiting one, I think, about the second or third trip I went back, and the next trip it seemed like I had got that checked on him. Q. And then after that pneumonia followed? A. Yes, yes; practically. Q. That was your judgment that it was pneumonia? A. That is our judgment. Q. That is your judgment now? A. Yes. Q. And you say the symptoms of sunstroke are yawning and gaping and sighing and fainting? A. Yes, sir; at the beginning, when they are first sunstruck. Q. Very often a person faints from being overheated that don't have a sunstroke? A. A person will faint from different causes. A. Yes, sir. They are caused by different causes. Q. Generally caused by eating? A. Yes, and different things. Q. I understand that it is generally caused by something a man gets into his stomach? A. I don't know that it is more caused from that than from other things. Q. That one of the causes? A. Yes, one of the causes —getting food in the stomach that won't digest. Q. Bad digestion a cause of diarrhea? A. Yes. Q. And there are a good many causes for vomiting besides overheating? A. Yes, other causes for it. Q. And pneumonia comes from a germ, don't it? A. Some authorities claim it don't, but the authorities in this matter, amongst the best authorities—you can take the best of authorities, and they say that in a great majority of these cases it will develop into pneumonia. Q. Did I ask you that? I asked you if pneumonia didn't come from a germ? A. I told you some authorities claim it does and some claim it don't. Q. What do you say about it. A. All I got is what the authorities say, enough as it is. Q. What do you say to the jury about that; that it does or does not; or that you don't know? A. Well, I don't know whether it is caused from a germ. Q. A condition of vomiting comes from a disordered condition of the stomach, does it not? A. Yes, sir. This disordered condition of the stomach may cause a reflex of the nerve system; overheated or a sunstroke does affect the nerve centers of the brain. Q. Now, the ordinary causes of vomiting are what we would call a disordered stomach, is it not? A. Yes. Q. And you have got to have a disordered condition of the stomach before you can have vomiting? A. Yes, have to be a disordered stomach before you can have vomiting. By the Court: Is there any difference between the symptoms of a sunstroke and being overheated from

other causes? A. Well, there is a difference, but these differences may vary; two persons might have a sunstroke and not be the same symptoms in the one as in the other. Q. Ordinarily, what would be the difference in the symptoms of a sunstroke and being overheated from some other cause—the effect the same way generally? A. I don't really remember about that. I don't know."

With the evidence substantially as we have stated, the argument is made by counsel for the casualty company that, although it should be considered that this evidence was sufficient to show with reasonable certainty that the death of Pack was due to sunstroke, the action of the lower court in directing a verdict was correct, because the policy contract did not cover death from sunstroke under the circumstances shown. The policy contract sets out in the beginning that:—

"This policy provides indemnity for loss of life, or sight, dismemberment, or loss of time due to accidental injuries, and for loss of time due to sickness, subject to all conditions and limitations contained therein."

And it is urged that, as the purpose of the policy was to furnish indemnity only against death or injury from accidental causes, the sunstroke from which appellee suffered was not an accident within the fair meaning of the contract. In support of this position, the argument is made that it is not the injury or death that comes from an accident that determines whether or not the thing that produced it was an accident within the meaning of the policy, but it is the means or circumstances that preceded or brought about the accident which determine its quality. For example, if a passenger on a train should be compelled without his fault to leave the train between stations and be obliged to walk to the nearest station and on the way should suffer sunstroke, this would be an accidental sunstroke because it was occasioned by an unforeseen accident; but if the passenger voluntarily, and for some purpose of his own, left the train, and while walking to the station met with a sunstroke, it would not be an accident, although he could not reasonably have anticipated that sunstroke would follow his act of walking. Authorities giving some support to this contention are: Schmid vs. Indiana Travelers' Accident Ass'n, 42 Ind. App. 483, 85 N. E. 1032; Smith vs. Travelers' Ins. Co., 219 Mass. 147, 106 N. E. 607, L. R. A. 1915B, 872; Lehman vs. Great Western Accident Ass'n, 155 Iowa, 737, 133 Iowa, 752, 42 L. R. A. (N. S.) 562; Elsey vs. Fidelity & Casualty Co. (Ind. App.) 109 N. E. 413.

[1] But we cannot agree that the views expressed in these authorities should control this case, although it is clear that if this construction should be adopted the sunstroke clause would not indemnify Pack against death, if we should assume that his death was directly caused by sunstroke independent of other causes, because when Pack was stricken he was voluntarily pursuing in the

usual way his regular occupation, and there was nothing unusual in what he was doing, nor did anything unexpected or unforeseen or accidental precede the stroke.

We do not think it would be a fair or reasonable construction of the contract to exempt the company from liability if the death of Pack was caused directly by a sunstroke. The policy expressly recognizes that death may result from sunstroke accidentally suffered, and undertakes to indemnify the insured against an accident of this nature. So that, if we should come to apply the provisions of this policy to death caused directly by sunstroke, the only question left open would be whether or not a sunstroke suffered under the circumstances described was accidental within the meaning of the policy. The policy stipulates that the company will pay the beneficiary the principal sum of this policy "if sunstroke caused by the direct effect of the sun's rays, * * * accidentally suffered by the insured shall result directly, independently and exclusively of all other causes in the death of the insured within ninety days from the date of the exposure."

[2] Now, is this indemnity to be limited to sunstroke that is preceded by and caused by an accident or an unforeseen or unexpected event, or is it to embrace sunstroke produced by causes that could not be reasonably anticipated and which occur while the insured is going about his business in the usual way? If the latter, then this clause would cover a sunstroke suffered under the circumstances described in the evidence, because it is a matter of common knowledge that sunstroke in this climate is not the natural or probable result of engaging in ordinary manual labor on a warm summer day. On the contrary, it is a very unexpected and unusual occurrence. It is so rare indeed that it may well be called an "accident," which is defined by Webster as:—

"An event that takes place without one's foresight or expectation. An undesigned, sudden and unexpected event, * * * happening by chance or unexpectedly, taking place not according to the usual course of things."

The same definition in different words is found in *Corpus Juris*, vol. 1, p. 390, and in *A. & E. Ency. of Law*, vol. 1, p. 293. And this definition of an "accident" seems peculiarly fitted to the facts of this case. Here Pack was engaged with other laborers in doing ordinary manual labor such as great numbers of laboring men are engaged in every day. They are accustomed to working in exposed places on hot days and do not anticipate any ill effects from the heat. Occasionally, perhaps one of them may have a sunstroke; but, if he does, it is such an unexpected, unforeseen, and unusual thing as to come well within the definition of an "accident."

Unless the clause in this contract providing indemnity against sunstroke is construed to embrace cases like the one we have, it is deceptive and misleading and fails to afford the protection

its reading implies. If an insured who should suffer sunstroke when engaged in his usual occupation or in doing the things he usually does is not to be protected by this clause in the policy, it has little beneficial meaning; for, according to the construction contended for, the insured would not be protected in any state of case unless the sunstroke happened while the insured was by accident or misfortune involuntarily placed in a position or surrounded by conditions that would subject him to the rays of the sun in an unexpected and unforeseen manner. It is, of course, true that sunstroke suffered in this way would be accidental, but not more so than would sunstroke suffered under ordinary conditions when it could not be reasonably anticipated or foreseen that it would happen. The very purpose of accident insurance is to protect the insured against accidents that occur when he is going about his business or attending to his work or affairs in the usual way without any thought of being injured or killed, and when there is no probability, in the ordinary course of human experience, that he will meet with accident or death. The reason why men secure accident insurance is to protect them against unforeseen and unexpected accidents that may happen in the ordinary course of their lives, and when they are pursuing in the usual way their daily vocations, or doing in the ordinary way the things that men do in the common, everyday affairs of life. Nearly all accidents happen when people are going about their business in the usual way and are voluntarily doing the things before them to do. There are many clauses in this policy protecting the insured against accidental injury or death, and, if the argument of counsel is sound when applied to the sunstroke clause in the policy, there seems no good reason why the construction contended for should not embrace all of the other indemnity features, with the result that the insured would find himself without protection against the very things for which he secured the insurance as indemnity.

We therefore hold that, although Pack was voluntarily engaged in working in the sun, the sunstroke was, nevertheless, an accident that he could not reasonably have foreseen or anticipated, although, if it might have reasonably been expected that a sunstroke would follow as a natural and probable result of his work on this hot day, the stroke was not an accident within the meaning of the policy. *American Accident Co. vs. Reigart*, 94 Ky. 547, 23 S. W. 191, 15 Ky. Law Rep. 469, 21 L. R. A. 651, 42 Am. St. Rep. 374; *American Accident Co. vs. Carson*, 99 Ky. 441, 36 S. W. 169, 18 Ky. Law Rep. 308, 34 L. R. A. 301, 59 Am. St. Rep. 473; *Massachusetts Bonding & Insurance Co. vs. Duncan*, 166 Ky. 515, 179 S. W. 472; *General Accident & Life Assurance Corp. vs. Meredith*, 141 Ky. 92, 132 S. W. 191; *Bryant vs. Continental Casualty Co. (Tex.)* 182 S. W. 673; *Western Commercial Travelers' Ass'n vs. Smith*, 85 Fed. 401, 29 C. C. A. 223, 40 L. R. A. 653;

Fidelity & Casualty Co. vs. Carroll, 143 Fed. 271, 74 C. C. A. 409, 5 L. R. A. (N. S.) 657, 6 Ann. Cas. 955.

[3] The remaining question is the sufficiency of the evidence to show that the death of Pack was due directly, independently, and exclusive of all other causes to sunstroke. Unless it was, the policy did not furnish indemnity. Upon this issue we think the beneficiary failed to make out a case. The evidence does not sufficiently show any reasonable or natural connection between the sunstroke on the 6th day of June and the death from pneumonia on the 10th day of July, or that the death of Pack was due directly and exclusive of all other causes to sunstroke. On the record as we read and understand it, leaving out of view the evidence for the casualty company showing that the sunstroke could not under the facts stated have produced the pneumonia, it would be the merest speculation to say that Pack died from the effects of the sunstroke. *Aetna Life Ins. Co. vs. Bethel*, 140 Ky. 609, 131 S. W. 523.

The judgment is affirmed.



SUPREME JUDICIAL COURT OF MASSACHUSETTS.

ESSEX.

COLLINS

vs.

CASUALTY CO. OF AMERICA.*

1. INSURANCE—"ACCIDENT" INSURANCE—LIABILITY.

Under accident policy, insuring against loss of life, limb, sight, and time resulting from bodily injuries effected through accidental means, recovery may be had for the death from a rupture which resulted from a fall, though insured was predisposed to rupture.

(For other cases, see Insurance, Cent. Dig. §§ 1178, 1186; Dec. Dig. § 466.)

(For other definitions, see Words and Phrases, First and Second Series, Accident.)

2. INSURANCE—ACCIDENT INSURANCE—POLICY—INJURIES.

Where a policy insured against loss of life, limb, sight, and time, resulting from bodily injuries effected directly and independently of all other causes through accidental means, the insurer is liable for the death of the insured as a result of an operation necessary to cure a rupture caused by an accidental fall.

(For other cases, see Insurance, Cent. Dig. §§ 1178, 1186; Dec. Dig. § 466.)

* Decision rendered, May 23, 1916. 112 N. E. Rep. 634.

3. INSURANCE—ACCIDENT INSURANCE—POLICY—CONSTRUCTION.

Where etherization was an incident of the operation, the fact that the death resulted from etherization does not free the insurer from liability.

(For other cases, see Insurance, Cent. Dig. §§ 1178, 1186; Dec. Dig. § 466.)

4. INSURANCE—ACCIDENT INSURANCE—POLICY.

Under St. 1907, c. 576, § 21, declaring that no warranty made in the negotiation of a policy of insurance will avoid the policy unless it is made with actual intent to deceive or the matter warranted increased the risk of loss, warranties contained in an insurance policy are deemed to be made in the negotiation.

(For other cases, see Insurance, Cent. Dig. §§ 568, 569; Dec. Dig. § 268.)

5. INSURANCE—ACCIDENT INSURANCE—BURDEN OF PROOF.

An insurer, seeking to avoid an accident policy on the ground of false warranty, has the burden of proving that the warranty increased the risk, or was made with intent to deceive, and so fell within St. 1907, c. 576, § 21.

(For other cases, see Insurance, Cent. Dig. § 1555; Dec. Dig. § 646[3].)

6. INSURANCE—ACCIDENT INSURANCE—JURY QUESTION.

In an action on an accident policy, where the death of insured resulted from a rupture, and his physical structure was shown to be such that he had a predisposition to rupture, the question whether his warranty that he was in sound condition increased the risk within St. 1907, c. 576, § 21, so as to avoid the policy, held for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1737-1741, 1758-1760; Dec. Dig. § 668[9].)

7. INSURANCE—ACCIDENT INSURANCE—INSTRUCTION.

In an action on an accident policy, where the insurer set up the falsity of a warranty contained in the policy, a charge that while persons are presumed to know the contents of a contract which they sign or accept, the presumption is not conclusive was warranted.

(For other cases, see Insurance, Cent. Dig. 1774-1776; Dec. Dig. § 669[4].)

Exceptions from Superior Court, Essex County; Joseph F. Quinn, Judge.

Action by one Collins against the Casualty Company of America. There was a verdict for plaintiff and defendant excepted. Exceptions overruled.

Sweeney & Cox, of Lawrence, for Plaintiff.
Peabody, Arnold, Batchelder & Luther, of Boston, for Defendant.

LORING, J.

This is an action by the beneficiary named in a policy of accident insurance to recover for the death of the assured. The assured on December 15, 1910, went from his office with a coal hod to get some coal from a coal bin near by. While returning with the coal he slipped, fell and ruptured himself. It was in evidence and must be taken to have been conceded, that the plain-

tiff from birth had a predisposition to rupture because the inguinal canal was not closed as it ought to have been but that by virtue of his muscles the opening had been kept shut until the accident in question. There was also evidence that the rupture was an irreducible one and that for a man of the plaintiff's years and condition a suspensory truss was not the treatment to be adopted, but that an operation if not necessary was the only proper way in which the injury should be treated, and the assured was so advised. In consequence of that advice he was operated upon on December 28, 1910, and died on January 10, 1911. It appeared that so far as the immediate operation was concerned it was successful, that is to say, there was a satisfactory healing of the wound. But some three or four days after the operation the assured was taken with vomiting, was unable to hold food for any protracted period and died owing to some "obscure physiological poisoning due to some unknown changes in bodily functions due to etherization."

By the terms of the policy the defendant insured the assured "against loss of life, limb, sight and time resulting from bodily injuries * * * effected directly and independently of all other causes through accidental means." The policy further provided under the heading "Indemnity for Loss of Life, Limb or Sight" that:—

"If any one of the losses named in this section shall result directly and independently of all other causes from such injuries within ninety days from date of accident, but not necessarily causing immediate and continuous disability, the company will pay the sum set opposite such loss."

The jury found a verdict which represented the sum payable for death happening in accordance with the terms of the policy and the case is here on exceptions taken by the defendant.

[1] 1. The first exception argued by the defendant is that taken to the refusal of the presiding judge to give the first and twenty-sixth rulings asked for by him.¹

The first contention made by the defendant in support of these exceptions is that the assured's predisposition to rupture was a cause of the injury to the assured and therefore that there was no evidence on which the jury could find that the death of the assured resulted from a bodily injury effected directly and independently of all other causes through accidental means. But we are of opinion that the jury were warranted in finding that the predisposition to rupture was not a cause of the accident. It is not unlike the streptococcus germs in the nose in *Smith vs. Travelers' Ins. Co.*, 219 Mass. 147, 106 N. E. 607, L. R. A. 1915B, 872, and the disease of diabetes in *Cheswell vs. Fraternal Acc. Ass'n*, 199 Mass. 267, 85 N. E. 96. See, also, in this connection Bohaker

¹ First: On all the evidence the plaintiff is not entitled to recover.

Twenty-sixth: If the plaintiff is unable to establish the precise cause of the insured's death, he cannot recover.

vs. Travelers' Ins. Co., 215 Mass. 32, 102 N. E. 342, 46 L. R. A. (N. S.) 543.

[2] The more difficult question arises however under the defendant's contention that there was no evidence that the death of the assured resulted "directly and independently of all other causes" from the accidental fall which the assured suffered on December 15, 1910. So far as we know the true construction of that provision of the policy is a question of novel impression. The provision of the policy in question in *Cheswell vs. Fraternal Acc. Ass'n*, ubi supra, was that the company would agree to pay to the beneficiary "the sum of twelve hundred fifty dollars if the death of the certificate holder shall result from such injuries alone" within ninety days from the date of said accident. And there was a similar provision in *Freeman vs. Mercantile Acc. Ass'n*, 156 Mass. 351, 30 N. E. 1013, 17 L. R. A. 753. But the decisions in those cases do not go far as a help in the decision of the case at bar. Neither the plaintiff nor the defendant has brought to our attention any case involving a consideration of the proper construction of such a clause in a policy of accident insurance and no case of that kind has come to our attention.

The defendant has not laid stress upon the provision of the policy that the death must result "directly" from the injury in question. This may be because of the provision that the injury need not cause "immediate" disability. Under those circumstances we do not stop to consider that provision and proceed to the consideration of the provision that death must result from the injury "independently of all other causes."

[3] Having in mind the apparent purpose and intent of the parties in taking out and granting a policy of accident insurance, we are of opinion that in a case where a surgical operation becomes necessary to deal properly with the effects of an injury within the policy of accident insurance and the assured dies as a result of the operation death results "independently of all other causes from such injuries." It is plain, and in fact it was testified to by one of the doctors, that "the operation consisted of the etherization, just as essentially as it did of my [the] operation on him, cutting with a knife." If the jury found in the case at bar (as indeed they must have found) that the occasion of the death was "an obscure physiological poisoning due to certain unknown changes of the bodily functions brought on by etherization" they were bound, or at least they were warranted in finding that that was a mere incident of the operation, which operation again was the only proper way of dealing with the rupture which was caused by "accidental means" within the terms of the policy. If they did so find the assured came to his death from an incident of what was a proper treatment of the injury (which injury was within the policy). If this effect of etherization was an incident of the operation and that was found to be a necessary or proper result of

the injury, it was not another outside cause but an incident of a cause within the policy and in that case death resulted "directly and independently of all other causes from such (the) injuries."

It follows that there was evidence for the jury and the first ruling was properly refused, and, also, that if the jury drew the inferences we have just stated the plaintiff had established the cause of the death of the assured and the twenty-sixth ruling ought not to have been given.

2. From what has been said it is evident that the exception taken to the refusal to give the twelfth ruling asked for was rightly refused.²

As we have held already, the question for the jury was whether the assured died from the operation including one of its incidents. If he did, it was as matter of law not a cause of the death and therefore the twelfth ruling asked for was wrong.

[4-6] 3. The twenty-first ruling asked for was rightly refused.³
By St. 1907, c. 576, § 21, it is provided that:—

"No * * * warranty made in the negotiation of a * * * policy of insurance by the assured or in his behalf shall be deemed material or defeat or avoid the policy or prevent its attaching unless such * * * warranty is made with actual intent to deceive or unless the matter * * * made a warranty increased the risk of loss."

It is settled that the words "in the negotiation of a policy of insurance" included the issuance of the policy itself. *Everson vs. General Accident, etc., Assurance Corporation*, 202 Mass. 169, 88 N. E. 658.

There was no evidence that this warranty was made with the intent to deceive. The only question was whether it was a warranty which increased the risk of loss. The burden of proving that this warranty increased the risk of loss was upon the defendant. As a general rule it is for the jury to decide whether as matter of fact an affirmative defense has been made out in the evidence. *Leary vs. William G. Webber Co.*, 210 Mass. 68, 96 N. E. 136.

Without stopping to consider the question whether on the evidence there was a question of fact for the jury with respect to the fact that the assured was not in sound condition physically, when it is the fact that thirty per cent of all men have a predisposition to rupture, it was for the jury to determine whether that fact increased the risk of loss.

There was evidence (not objected to) directly to the fact that

² Twelfth: If the jury believe that the wearing of a truss would have adequately controlled the hernia, and if they further believe that Patrick H. Collins voluntarily submitted himself to a surgical operation, and if they further believe that the cause of his death was the surgical operation, it cannot be said that his death resulted directly and independently of all other causes from the injuries received on December 15, 1910.

³ Twenty-first: Statement Q in the schedule of warranties contained in the policy issued to Patrick H. Collins, that he was in sound condition physically, was untrue and the matter there made a warranty increased the risk of loss.

not only that a predisposition to rupture increased the loss, but that accident insurance companies generally did not take a risk in such a case. But the jury were not bound to believe that testimony. Lindenbaum vs. New York, New Haven & Hartford R. R., 197 Mass. 314, 84 N. E. 129. And a predisposition to rupture does not come within the cases of Brown vs. Greenfield Life Association, 172 Mass. 498, 53 N. E. 129; Rainger vs. Boston Mutual Life Association, 167 Mass. 109, 44 N. E. 1088; Dolan vs. Mutual Reserve Fund Life Association, 173 Mass. 197, 53 N. E. 398.

[7] 4. In his charge to the jury the presiding judge said:—

“All parties to a contract, whatsoever contract it may be, who sign it, are presumed to know the terms thereof; but this presumption is not conclusive.”

It is plain from the context, that this was said in connection with the question whether the insured had an actual intent to deceive the defendant in respect to the statements in the warranties made by the assured including that marked Q. In that connection the construction was correct. The defendant has argued that the statement was not in terms so limited. But we are of opinion that that contention is not correct.

Exceptions overruled.

**SUPREME COURT OF NEW YORK.****TRIAL TERM, NEW YORK COUNTY.****HOPKINS****vs.****CONNECTICUT GENERAL LIFE INS. CO.*****1. INSURANCE—CONTRACT—RIDER—SIGNATURE BY INSURER.**

A rider attached to an accident policy, providing that the policy does not cover loss or disability caused directly or indirectly by any act of any of the belligerent nations engaged in the European war, need not be signed by the insurer, since it contains no promise or undertaking on its part, and does not waive any of its rights or impose any obligation upon it.

(For other cases, see Insurance, Cent. Dig. §§ 212, 213; Dec. Dig. § 133[3].)

* Decision rendered, March, 1916. 158 N. Y. Supp. 79.

2. INSURANCE—CONSTRUCTION OF CONTRACT—CHANGE OF POLICY.

A clause in an accident policy providing that no agent has authority to change the policy or waive any of its provisions, and no change shall be valid unless approved by an executive officer of the insurer and such approval be indorsed on the policy, is solely for the benefit of the insurer.

(For other cases, see Insurance, Cent. Dig. §§ 952-954; Dec. Dig. § 376[1].)

3. INSURANCE—CONTRACT—AUTHORITY OF AGENT.

Restrictions in an accident policy on an agent's power to modify it do not apply to a rider attached to the policy at the time of its execution, but only to a change after the contract has been made.

(For other cases, see Insurance, Cent. Dig. §§ 952-954; Dec. Dig. § 376[1].)

4. INSURANCE—CONTRACT—AUTHORITY OF AGENT—ESTOPPEL OF BENEFICIARY.

Where insurance agents were authorized to sign a rider, to be attached to an accident policy, providing that the policy should not cover loss caused directly or indirectly by any act of any of the belligerent nations engaged in the European war, and to deliver the policy to insured only "if and when he signed the rider," the beneficiary of the policy cannot recover on the ground of invalidity of the rider, since, if that fails for want of authority of the agents, the contract as a whole is void.

(For other cases, see Insurance, Cent. Dig. §§ 246-249; Dec. Dig. § 138[1].)

5. INSURANCE—COMPANIES—REGULATION—FILING FORMS.

Insurance Law (Consol. Laws, c. 28) § 107, as added by Laws 1913, c. 155, requiring the forms of policies to be filed with the Superintendent of Insurance, requires the general form of each class of riders to be attached to policies to be filed.

(For other cases, see Insurance, Cent. Dig. § 10; Dec. Dig. § 10.)

6. INSURANCE—LIABILITY OF INSURANCE—VALIDITY OF CONDITIONS.

Under Insurance Law, § 107, as added by Laws 1913, c. 155, requiring insurers to file with the Superintendent of Insurance the forms of policies issued, and providing, in subdivision "i," that a policy issued in violation of this section shall be held to be valid, but shall be construed as provided in the section, and when any provision in the policy is in conflict with any provision of the section, the rights, duties, and obligations of the insurer, the policyholder, and the beneficiary shall be governed by the section, the fact that a war rider attached to an accident policy has not been filed with the Superintendent of Insurance does not render it invalid, and authorize a recovery on the policy without reference to its provisions, but merely subjects the insurer to the penalties provided by the law.

(For other cases, see Insurance, Cent. Dig. §§ 246-249; Dec. Dig. § 138[1].)

7. INSURANCE—CONTRACT—FORM AND REQUISITES.

Insurance Law, § 107, subd. "b," cl. 6, as added by Laws 1913, c. 155, requiring any portion of a policy which purports, by reason of the circumstances under which a loss is incurred, to reduce any indemnity promised therein to an amount less than that provided for the same loss occurring under ordinary circumstances, to be printed in bold-faced type and with greater prominence than any other portion

of the text, applies only to an exception in the main part of the policy, and not to exceptions consisting of riders or attached papers.
(For other cases, see Insurance, Dec. Dig. § 133[2].)

Action by the widow of Albert L. Hopkins against the Connecticut General Life Insurance Company. Complaint dismissed on the merits.

Thayer & Van Slyke, of New York City, for Plaintiff.
George Coggill, of New York City, for Defendant.

SHEARN, J.

On April 29, 1915, defendant's agents in New York delivered to Albert L. Hopkins a policy of accident insurance issued by defendant. The application was signed by Hopkins and in the event of his death, resulting from the injuries insured against, the policy provided for the payment of \$40,000 to his wife, the plaintiff herein. Hopkins stated to defendant's agent at the time of making application that he intended to travel abroad. The policy was delivered to him after he had signed a rider attached to the policy reading:—

"Rider to be attached to and form part of policy No. C. F. 6674, issued by the Connecticut General Life Insurance Company to Albert Lloyd Hopkins.

"In consideration of the issuance of the policy, I hereby agree for myself, my beneficiary, our respective executors, administrators or assigns, that this policy does not cover any loss or disability resulting from bodily injuries caused directly or indirectly by any act of any of the belligerent nations engaged in the present European war.

"Dated this 29th day of April, A. D. 1915.

"Connecticut Gen. Life Ins. Co.

"Wells, Potter, Fish & Ustick, Inc.,

"By Frank H. Wells, Treasurer.

"A. L. Hopkins, Insured."

Wells, Potter, Fish & Ustick, Incorporated, is a domestic corporation, of which Frank H. Wells is treasurer and managing director. At and prior to the time of the issuance of the policy Wells, Potter, Fish & Ustick, Incorporated, had been authorized to act as agent for the defendant under section 91a of the Insurance Law and had been authorized by defendant to issue the policy involved in this action to Hopkins "if and when he signed the rider" above referred to. Wells, Potter, Fish & Ustick, Incorporated, had, with the knowledge and consent of defendant, made a practice of signing similar riders attached to similar policies. This rider was copied from a form prepared by an executive officer of defendant. Wells, Potter, Fish & Ustick, Incorporated, had no authority to issue a policy such as the one in suit to any person intending to travel abroad unless such person signed a rider similar to the one in question. After the policy was issued

Hopkins sailed on the Lusitania and was drowned while a passenger on that vessel when she was sunk by a submarine belonging to the German navy on May 7, 1915.

The learned counsel for the plaintiff contend that the rider, signed by the insured, excluding injuries caused by the acts of a belligerent from the risks insured against by the contract of insurance must be wholly disregarded as invalid: First, because it was not signed by an executive officer of defendant; second, because the form of the rider had not been filed with and approved by the superintendent of insurance of the state of New York before it was signed and attached to the policy; and, third, because the typewritten rider was not "printed in bold-faced type and with greater prominence than any other portion of the text of the policy." These three technical claims are wholly unrelated. Each must stand on its own merits.

[1-3] 1. The lack of the signature of an executive officer to the rider. In the first place there is no reason why the defendant should have signed the rider at all. It contains no promise or undertaking on the part of defendant, and does not purport to waive any of its rights or impose any obligation upon it. Plaintiff's counsel contend, however, that clause 2 of the standard provisions of the policy requires that the rider be signed by an executive officer. Clause 2 provides:—

"No statement made by the applicant for insurance not included herein shall avoid the policy or be used in any legal proceedings hereunder.

"No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid unless approved by an executive officer of the company and such approval be indorsed hereon."

Such provisions as to waiver and change in the policy are solely for the benefit of the insurance company. *Belt vs. American Central Ins. Co.* 29 App. Div. 546, 552, 53 N. Y. Supp. 316. Restrictions inserted in a policy upon an agent's power to modify the contract do not apply to the inception of the contract of insurance, but only to a change after the contract has been made. *Wood vs. American Fire Ins. Co.*, 149 N. Y. 382, 386, 44 N. E. 80, 52 Am. St. Rep. 733. The rider effected no *change* in the policy. Its provisions are just as much a part of the policy as though written or printed upon the main part thereof. The standard provisions of the policy distinctly provide:—

"This policy includes the indorsements and attached papers, if any, and contains the entire contract of insurance."

In the case at bar the war rider was attached and has been signed by plaintiff's husband and defendant's agents, so that it is impossible to hold that the contract of insurance was changed, as it never had any existence apart from the rider.

[4] But even if, contrary to the settled law, it could be held that the limitation upon the agent's authority applied to changes

from the printed form of the policy in the inception of the contract of insurance, this would avail the plaintiff nothing, since, although not executive officers of defendant, Wells, Potter, Fish & Ustick, Incorporated, were authorized by defendant to sign the rider and make the contract of insurance in exactly the form in which it was made, if any signature by or on behalf of the defendant should be regarded as necessary. This clearly appears from the facts that they were defendant's agents, they counter-signed the policy as such, they were authorized to deliver the policy to Hopkins "if and when he signed the rider," they had with the knowledge and consent of defendant been in the habit of signing similar riders for defendant, and they had no authority to deliver any such policy to any one intending to travel abroad unless such a rider was signed and attached to the policy. In cases where the authority of an agent to bind his principal is in question, the issue is whether he actually had authority, not whether some other agent or executive officer might not have bound the principal also, and, if he actually had authority, it makes no difference that he was not an executive officer of the principal. As forcibly queried by defendant's learned counsel:—

"If, as plaintiff contends, Wells, Potter, Fish & Ustick, Incorporated, could not bind defendant by signing its name to the war rider, how can it be contended that they could bind defendant by issuing and delivering a policy without the war rider, when it is also distinctly stipulated that they could not deliver the policy to Hopkins without that rider being attached and signed by him?"

The plaintiff's challenge of the agent's authority to make the contract upon the terms as expressed in the instrument as delivered, is equivalent to an assertion that no contract was made, and this would leave plaintiff without a cause of action. One party to a contract, made through an agent of the other, cannot, by proving that the agent exceeded his authority claim that the parties actually made a different contract because the making of such different contract would have been within the agent's power. It is evident from the fact that Hopkins signed the rider that it expressed his intention as to the contract he was making. It is equally evident from the fact that the defendant limited its agents only to this rider that it did not intend to make any contract of insurance without the rider. In substance, the court is being asked to substitute for the contract which has been made, or intended to be made, one which Hopkins did not intend to make and which defendant's agents did not intend to make and were not authorized to make.

[5] 2. The failure to file the rider with the superintendent of insurance. I do not agree with the defendant's contention that section 107 of the Insurance Law, properly construed, does not require the form of riders or other attached provisions of an accident policy to be filed. It does require the "form of policy" to be filed. The rider is just as important a part of the policy as

any other. It affects the risk, and very naturally affects the premium rates. The claim that the necessity of filing the form of proposed riders would cripple the accident insurance business and amount to a practical impossibility does not appeal to me as sound. The very policy in question contains a hernia rider, the form of which was filed by the defendant and approved by the superintendent of insurance before the policy was executed. The law does not require that each individual rider should be filed. It is sufficient to file the general form of each class of riders. In the case of a substantial departure from any approved form of rider it is no hardship to require the insurance company to file same and secure approval before issuing the policy.

[6] But the plaintiff claims that the mere failure to file the rider renders it invalid, and that it can be wholly disregarded, and the contract read as though executed without any rider. Where the court is asked by force of a legislative enactment to substitute for the written contract entered into by the parties a contract clearly different from that which both of them intended, the language of the statute relied upon to accomplish this result must be clear and explicit. No such intent or language can be found in section 107 of the Insurance Law. The section, subdivision "i," provides:—

"A policy issued in violation of this section, shall be held to be valid, but shall be construed as provided in this section, and when any provision in such a policy is in conflict with any provision of this section, the rights, duties and obligations of the insurer, the policyholder and the beneficiary shall be governed by the provisions of this section."

This language is plain and the meaning clear. A policy issued in violation of the section is nevertheless valid, and shall be construed as provided in the section. These provisions examined show that no provision in the policy or attached papers which purports to contradict or vary any of the standard provisions of the policy is of any avail to accomplish that purpose. Any provision of the policy which conflicts with any provision of the section is equally to be disregarded. But the rider in the case at bar does not purport to vary, alter, or extend any standard provision of the policy or of the statute. The standard provisions do not deal with the nature of the risk insured against, nor do the provisions of this section. The long line of cases cited in support of the plaintiff's contention have to do with the invalidity of provisions in insurance contracts that conflict with the statute or with public policy. It is, of course, well settled that insurance companies may not declare a forfeiture of policies without complying with certain notice conditions. But such cases are not at all in point. Such provisions are void, because repugnant to statute or to sound public policy. But there is nothing in this statute declaring or indicating that a rider not filed shall be invalid. Nor

does any consideration of public policy require or justify any such result. Such a holding would lead to the most unjust consequences. Suppose a policy was issued, no part of which had been filed; would it be wholly invalid? The statute says it would not. Section 107, subd. "i."

Again, as illustrated by defendant's counsel, assume that the defendant had filed and the superintendent of insurance had approved a form of accident policy insuring against injuries received while traveling on a railroad on land, and that the insured had applied to defendant for a similar policy insuring him against injuries received while traveling on a vessel on the ocean, and that without waiting to file this form of policy the defendant had issued it to him, and he had been injured while on the vessel. Under these circumstances it could not be contended with any plausibility or reason that the filed and approved form of policy should be substituted for the actual policy issued. Yet the plaintiff's argument, carried to its logical conclusion, leads to just such an inequitable result.

Plaintiff's counsel contend that to hold the rider valid where defendant has failed to file it nullifies the statute, and in effect permits the insurance company to incorporate in a policy with entire immunity clauses which would never receive the sanction of the Superintendent of Insurance. This is not correct, however, for the statute provides penalties for failure to obey the statute, and even subjects the offending company to expulsion from the state. That is much more sensible and just than to invalidate the contract, or any essential part of it, merely because it was not filed and approved before it was issued. If such were the law, no one would know whether he had a valid and enforceable contract of insurance until he had made a search at Albany for the form and approval of his policy.

[7] 3. The failure to print the rider in bold-faced type. This ground is not very seriously urged and requires little consideration. Subdivision "b" (6) of section 107 provides:—

"No such policy shall be so issued or delivered * * * (6) unless the exceptions of the policy be printed with the same prominence as the benefits to which they apply, provided, however, that any portion of such policy which purports, by reason of the circumstances under which a loss is incurred, to reduce any indemnity promised therein to an amount less than that provided for the same loss occurring under ordinary circumstances, shall be printed in bold-faced type and with greater prominence than any other portion of the text of the policy."

This paragraph applies only to an exception in the main part of the policy and not to exceptions consisting of riders or attached papers. The purpose of this was to give prominence to an exception, so that it would not escape the attention of the insured by being tucked away somewhere in his policy. There is no dan-

ger of overlooking a limitation of the risk contained in an attached paper signed by the applicant for the policy and referring only to the limitation. This war rider was given great prominence. It was separately signed by the insured, a business man and president of a great shipbuilding company, and it is unreasonable to presume that he did not read the rider that he signed. From its prominent position, and the fact that his signature was attached to it, it seems evident that it was in a position to be, and was, brought particularly to his attention. The plaintiff's counsel have been commendably ingenious, industrious, and earnest in their effort to maintain a recovery upon this policy; but the equities are all against the plaintiff, and the technical grounds advanced, when examined, are found to be unconvincing and unsound.

The complaint must be dismissed upon the merits, with costs.



**SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, THIRD DEPARTMENT.**

TROMBLEE

vs.

NORTH AMERICAN ACC. INS. CO.*

1. INSURANCE—ACTIONS—SUFFICIENCY OF EVIDENCE.

In suit upon accident policy for death, evidence that deceased, in getting out of his hack, fell on his back, and seemed dazed, and complained of injury to his head, dying two days later, defendant claiming death from deceased's heart, *held* to sustain a verdict for beneficiary.

(For other cases, see Insurance, Cent. Dig. §§ 1719, 1721, 1722; Dec. Dig. § 665[5].)

4. INSURANCE—PROOF OF LOSS—TIME OF PROOF.

Where notice of an accident was required in an accident policy to be given as soon as reasonably possible, and deceased died December 31st, and notice was mailed to local agents the following January 19th, and received by the head office January 23d, *held*, refusal to hold as a matter of law that the notice was not timely is not error.

(For other cases, see Insurance, Cent. Dig. §§ 1747, 1749, 1750, 1766, 1768; Dec. Dig. § 668[14].)

Appeal from Trial Term, Warren County.

Action by Lilla D. Tromblee against the North American Accident Insurance Company. From a judgment for plaintiff upon a jury verdict, and an order denying defendant's motion for a new trial, defendant appeals. Affirmed.

* Decision rendered, May 3, 1916. 158 N. Y. Supp. 1014.

Argued before Kellogg, P. J., and Lyon, Howard, Woodward, and Cochrane, JJ.

Chambers & Finn, of Glens Falls (Walter A. Chambers, of Glens Falls, of counsel), for Appellant.

James McPhillips, of Glens Falls, for Respondent.

JOHN M. KELLOGG, P. J.

[1] It was for the plaintiff to allege and prove that bodily injuries sustained by her husband through accidental means, independently and exclusive of all other causes, resulted in his death. She alleges he was injured December 29, 1914; he died December 31st. The defendant denies the injury, and contends that death resulted from heart disease and other diseases. A hackman swears that the deceased, in getting out of his hack, fell upon his back and head, and seemed dazed. Upon entering his house, his wife, the plaintiff, says he was dazed, and complained of injury at the back of his head, and apparently suffered from the injury. Plaintiff's expert evidence tends to show that death resulted from concussion of the brain. The defendant's evidence is to the contrary, and indicates that it resulted from a diseased heart, and that the deceased had other diseases which might well have caused his death. The lines were sharply drawn; able experts were called; their testimony cannot be reconciled; the judge, in substance, so informed the jury, and it was a question of fact for the jury, after having heard the experts and considered in full the details and results of the autopsy, as to what was the cause of the death. They have decided all the questions of fact in favor of the plaintiff, and we are unable to say that such decision is not fairly sustained by the evidence.

[2, 3] The plaintiff's daughter was not at home at the time of the alleged injury. She returned home at about 10 o'clock at night, and did not see her father until the next morning at breakfast. She was asked, "Did he complain of pain?" The defendant's counsel objected as incompetent, improper, irrelevant, and not a part of the res gestæ. The objection was overruled and the defendant excepted. "A. Yes, sir. Q. And did he tell you where it was? A. In the small of the back and right down here in the neck." It is urged that this evidence was incompetent, and calls for a reversal. Prior to the time when a party could be sworn in his own behalf, it was competent to prove his declarations of pain. Caldwell vs. Murphy, 11 N. Y. 416; Werely vs. Persons, 28 N. Y. 344, 84 Am. Dec. 346. But when a party was permitted to be sworn in his own behalf it was held the rule was changed. The admission of such testimony seemed to have rested upon necessity, as otherwise there was no way of proving pain. But when the party could be sworn there was no necessity, and the evidence was excluded. Roche vs. Brooklyn City & Newtown R. R. Co., 105 N. Y. 294, 296, 11 N. E. 630, 59 Am. Rep. 506.

Although involuntary exclamations, which are natural concomitants and manifestations of pain and suffering, are still admissible where they form part of the *res gestæ*. *Kennedy vs. Rochester City & Brighton Railroad Co.*, 130 N. Y. 655, 658, 29 N. E. 141. The plaintiff, by reason of her husband's death, cannot prove that he was suffering pain, or where the pain was, otherwise than by his declarations, and it seems that within the rule of the cases above cited such proof is admissible. We conclude, therefore, that the exception to this evidence was not well taken.

[4] The policy required that notice of the accident must be given to the company at its home office in Chicago "as soon as may be reasonably possible." The notice in this case was mailed to the local agents of the defendant at Glens Falls January 19th, and by them was forwarded to the Chicago office of the defendant, and it admitted receipt thereof to the plaintiff's attorney January 23, 1915. The court properly refused to hold as matter of law that the notice was not timely and properly given under the policy. The plaintiff had a reasonable time under the circumstances in which to give the notice. It is evident that for some time after her husband's death the plaintiff did not realize that death resulted from the injury.

[5] The complaint alleged that the insured, after alighting from an automobile, slipped and fell to the ground, receiving injuries covered by said policy, and from the effects of and as a result of which he subsequently died on the 31st of December, 1914. The defendant, at the opening of the trial, moved to dismiss the complaint, upon the ground that it did not appear that the death resulted directly from the accident, independently and exclusively of all other causes. The court held that the complaint, in substance, met the conditions of the policy; that if the death resulted from the accident there could be no other cause; that it alleged in substance that he died as the direct result of the accident, and that that implied that he did not die of anything else; but suggested that, if the complaint was defective, an amendment would be allowed. No amendment, however, was in form made. The defendant excepted. The form of the complaint, as applied to this policy, is not to be commended, and while we think an amendment should have been in fact made, the question has been fully litigated; the requests of the defendant that the death must have resulted directly, independently, and exclusively from the accident were charged; and it would seem to be a technical error now to reverse the judgment on account of the mere verbiage of the complaint, when the facts were fully litigated, the complaint fully understood, and the proof met the terms of the policy. We feel, if a technical error was committed in this respect, it should be disregarded.

The judgment should therefore be affirmed with costs.

Lyon, Howard, and Woodward, JJ., concur. Cochrane, J., concurs in result.

STANDARD ACC. INS. CO. vs. BROOM. (No. 17934.)*
(Supreme Court of Mississippi, Division B.)

1. INSURANCE—ACTIONS ON POLICY—EVIDENCE.

In an action to recover on an accident policy, evidence examined, and *held* sufficient to warrant a finding that death of insured was the result of accident.

(For other cases, see Insurance, Cent. Dig. §§ 1555, 1719, 1721, 1722; Dec. Dig. § 665[5].)

2. INSURANCE—ACTIONS ON POLICY—NOTICE PRECEDENT.

The provision in an accident policy requiring written notice to the insurer, within fifteen days after the accident for which claim is made, is void under Code 1906, § 3127, providing that any contract changing "the limitations prescribed in this chapter" shall be null and void.

(For other cases, see Insurance, Cent. Dig. §§ 1309, 1316, 1317; Dec. Dig. § 530.)

Appeal from Circuit Court, Lowndes County; Thomas B. Carroll, Judge.

Action by Mrs. Ida Broom against the Standard Accident Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Sturdivant, Owen & Garnett, of Columbus, for Appellant.
James T. Harrison, of Columbus, for Appellee.

* Decision rendered, May 15, 1916. 71 South. Rep. 653.



LEVY vs. FIDELITY & CASUALTY CO. OF NEW YORK.*
(Supreme Court of New York, Appellate Term, First Department.)

**INSURANCE—INDEMNITY INSURANCE—QUESTION FOR JURY
—INJURY OR DISABILITY.**

Evidence in an action upon an indemnity accident policy *held* to make plaintiff's injury or disability a question for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1745, 1763, 1764; Dec. Dig. § 668[11].)

Appeal from Municipal Court, Borough of Manhattan, Seventh District.

Action by Milton I. Levy against the Fidelity & Casualty Company of New York. From a judgment dismissing the complaint upon a trial before a jury, plaintiff appeals. Reversed, and new trial ordered.

Argued March term, 1916, before Lehman, Pendleton, and Whitaker, JJ.

* Decision rendered, May 9, 1916. 158 N. Y. Supp. 804.

Milton I. Levy, of New York City, for Appellant.
Nadal, Jones & Mowton, of New York City (Bernard G. Barton, of New York City, of counsel), for Respondent.



**APPLEBAUM *vs.* ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA. (No. 141.)*
(Supreme Court of North Carolina.)**

INSURANCE—MUTUAL BENEFIT INSURANCE—BENEFICIARIES.

Under the deceased's certificate of membership in defendant fraternal benefit association, providing for payment in case of death to plaintiff as his wife, and limiting beneficiaries to relatives by blood, marriage, or legal adoption, and persons dependent upon the member, plaintiff, the bigamous wife of the deceased, not being related or legally dependent, does not come within any of the classes named, and she is not entitled to take as the beneficiary of the contract.

(For other cases, see Insurance, Cent. Dig. §§ 1932, 1937, 1938; Dec. Dig. § 769.)

Appeal from Superior Court, Mecklenburg County; Lane, Judge.
Action by Carrie S. Applebaum against the Order of United Commercial Travelers of America. Judgment for the defendant, and plaintiff appeals. Affirmed.

J. F. Flowers, of Charlotte, and Anderson, Slate & D'Orr, of Atlanta, Ga., for Appellant.

Tillett & Guthrie, of Charlotte, for Appellee.

* Decision rendered, May 3, 1916. 88 S. E. Rep. 722.



**COMMONWEALTH BONDING & CASUALTY INS. CO. *vs.* KNIGHT. (No. 564.)*
(Court of Civil Appeals of Texas. El Paso.)**

1. INSURANCE—ACCIDENT INSURANCE—PROOF OF LOSS.

Proof of loss is waived when the insurer denies all liability under the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1391, 1392; Dec. Dig. § 559[2].)

3. INSURANCE—ACCIDENT POLICY—CONSTRUCTION.

An accident policy provided that, if any bodily injury should immediately and continuously from the date of the accident disable and prevent

* Decision rendered, April 27, 1916. Rehearing denied, May 18, 1916. 185 S. W. Rep. 1037.

the insured from performing any and every duty pertaining to his business or occupation, indemnity at the rate of \$35 per month should be paid for a period not exceeding twenty-four consecutive months, but only while the insured should be under regular treatment of a physician. Under the head "General Agreement" the policy declared that proof of loss should be given within ninety days after death, injury, or termination of disability, while a subsequent paragraph declared that final proof in all cases should be given in accordance with the general agreement. *Held* that, despite any hardship it might work on the insured, he was not entitled to payment of benefit for total disability until the period of disability had ceased.

(For other cases, see Insurance, Cent. Dig. § 1493; Dec. Dig. § 597.)

Appeal from Taylor County Court; E. M. Overshiner, Judge.

Action by J. A. Knight against the Commonwealth Bonding & Casualty Insurance Company, begun in justice's court, and appealed to county court. From a judgment there for plaintiff, defendant appeals. Reversed and dismissed.

S. P. Hardwicke, of Abilene, for Appellant.

Kirby, Scarborough & Davidson, of Abilene, for Appellee.



COMMONWEALTH BONDING & CASUALTY INS. CO.
vs. BRYANT. (No. 7399.)*

(Court of Civil Appeals of Texas. Dallas.)

6. INSURANCE—ACCIDENT INSURANCE—"TOTAL DISABILITY."

One need not be absolutely disabled to do some acts usually done by him in carrying on his occupation to be "totally disabled," within an accident policy.

(For other cases, see Insurance, Cent. Dig. § 1310; Dec. Dig. § 524.)

(For other definitions, see Words and Phrases, First and Second Series, Total Disability.)

7. INSURANCE—ACCIDENT INSURANCE—FURNISHING PROOF OF DISABILITY—WAIVER—EVIDENCE.

Evidence, in an action on an accident policy, *held* sufficient to establish waiver as to furnishing proof of continuance of disability.

(For other cases, see Insurance, Cent. Dig. § 1725; Dec. Dig. § 665[8].)

9. INSURANCE—PROOF OF LOSS—WAIVER OF PLEADING.

Facts, and not the evidence thereof, being all that is necessary to be pleaded, it is sufficient pleading of waiver in an action on an accident policy, to authorize the showing of conversations with defendant's agents, for plaintiff to plead that he was informed by defendant that further proofs of loss were unnecessary.

(For other cases, see Insurance, Cent. Dig. § 1634; Dec. Dig. § 645[3].)

* Decision rendered, April 8, 1916. Rehearing denied, May 13, 1916.
185 S. W. Rep. 979.

Appeal from District Court, Hunt County; A. P. Dohoney, Judge.
 Action by C. M. Bryant against the Commonwealth Bonding & Casualty Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Speer & Brown, of Ft. Worth, and Crosby, Hamilton & Harrell, of Greenville, for Appellant.
 L. L. Bowman, F. M. Kemp and Yates, Sherrill & Starnes, all of Greenville, for Appellee.



NORTH AMERICAN INS. CO. *vs.* JENKINS. (No. 7099.)*

(Court of Civil Appeals of Texas. Galveston.)

4. INSURANCE—ACCIDENT INSURANCE—PREMIUMS—TIME OF PAYMENT.

Whether time for payment of premiums on a policy of accident insurance is of the essence of the contract, depends altogether on the wording thereof, and it cannot be said that as a matter of law time is of the essence.

(For other cases, see Insurance, Dec. Dig. § 186[2].)

Error from Galveston County Court; George E. Mann, Judge.
 Action by Edna Jenkins against the North American Insurance Company. From a judgment of the county court affirming judgment of the justice court for plaintiff, defendant brings error. Reformed and affirmed.

Wilson & Webb, of Galveston, for Plaintiff in Error.
 O. S. York, of Galveston, for Defendant in Error.

* Decision rendered, Feb. 23, 1916. 184 S. W. Rep. 307.



FIRST TEXAS STATE INS. CO. *vs.* HERNDON. (No. 61.)*

(Court of Civil Appeals of Texas. Beaumont.)

INSURANCE—NOTICE OR PROOF OF LOSS—STATUTORY PROVISIONS.

Under Rev. St. 1911, art. 5714, providing that no stipulation in a contract requiring notice of any claim for damages as a condition precedent to the right to sue shall be valid unless reasonable, and that any such stipulation fixing the time at less than ninety days shall be void, a provision in a policy insuring against sickness, requiring that if the sickness continued for more than thirty days insured or his repre-

* Decision rendered, Feb. 10, 1916. 184 S. W. Rep. 283.

sentative should, as a condition precedent to a recovery furnish the insurer every thirty days a report in writing from his attending physician or surgeon, stating his condition and the probable duration of his disability, was void.

(For other cases, see Insurance, Cent. Dig. §§ 1328, 1330, 1332, 1337; Dec. Dig. § 539[1].)

Appeal from Jasper County Court; C. C. Brown, Judge.
Action by W. H. Herndon against the First Texas State Insurance Company. Judgment for plaintiff and defendant appeals. Affirmed.

Smith & Lanier, of Jasper, for Appellant.
C. C. Ingram, of Jasper, and R. S. Sanders, of Center, for Appellee.

**WESTERN INDEMNITY CO. ET AL. vs. MACKECHNIE.
(No. 7423.)***

(Court of Civil Appeals of Texas. Dallas.)

**2. INSURANCE—ACTION ON POLICY—DENIAL OF LIABILITY
—TIME TO SUE.**

Where an insurer absolutely denied its liability on an accident policy, the beginning of an action without regard to the provisions of the policy relating to the time in which suit might be brought theron was authorized.

(For other cases, see Insurance, Cent. Dig. § 1551; Dec. Dig. § 623[4].)

3. INSURANCE—CONSTRUCTION OF CONTRACTS.

A contract of insurance should be construed most favorably to the insured, and where its language is fairly susceptible of any construction making the insurer responsible for the loss or injury, it is the duty of the court to so construe it, though the court cannot undertake to make a new contract in disregard of the plain and unambiguous language used by the parties.

(For other cases, see Insurance, Cent. Dig. § 295; Dec. Dig. § 146[3].)

4. INSURANCE—ACCIDENT INSURANCE—CONSTRUCTION.

Under an accident policy stipulating that for total disability the insurer would make certain weekly payments, and that if during the period of such disability and within ninety days from the accident the injury should directly, independently and exclusively of all other causes result in permanent paralysis, the insurer would pay the principal sum, where insured, when injured by a fall, was suffering from a disease contributing to his paralysis, such paralysis was not the direct, independent, and exclusive result of the fall, though it hastened the paralysis, so as to entitle the insured to a recovery.

(For other cases, see Insurance, Cent. Dig. §§ 1178, 1186; Dec. Dig. § 466.)

* Decision rendered, April 1, 1916. Rehearing denied, April 29, 1916.
185 S. W. Rep. 615.

6. INSURANCE—ACCIDENT INSURANCE—ISSUE.

In an action on a policy of accident insurance to recover for paralysis alleged to have resulted from an accident or fall, where the evidence tended to show that other diseases caused the paralysis, defendant was entitled to have the issue as to whether such diseases caused the paralysis submitted to the jury.

(For other cases, see *Insurance*, Cent. Dig. §§ 1745, 1763, 1764; Dec. Dig. § 668[11].)

7. INSURANCE—ACCIDENT INSURANCE—LIABILITY.

Where arterio sclerosis and Bright's disease, with which insured was suffering, caused a stroke of paralysis consequent upon his falling, or where the injury received by him in his fall and such diseases concurred in causing the paralysis, the insurer was not liable, but if the injury alone caused the paralysis within ninety days, from the accident "directly, independently, and exclusively of all other causes," as provided by the policy, the insurer was liable.

(For other cases, see *Insurance*, Cent. Dig. §§ 1178, 1186; Dec. Dig. § 466.)

Appeal from District Court, Dallas County; E. B. Muse, Judge.

Suit by Ellen MacKechnie, guardian of Edward MacKechnie, against the Western Indemnity Company and others. Judgment for plaintiff, and defendants appeal. Reversed and remanded.

Love & Taylor and Carden, Starling, Carden, Hemphill & Wallace, all of Dallas, for Appellants.

Henry P. Edwards and Cockrell, Gray & McBride, all of Dallas, and R. R. Hazlewood, of Amarillo, for Appellee.

CASUALTY, SURETY AND MISCELLANEOUS.**UNITED STATES CIRCUIT COURT OF APPEALS.**

FOURTH CIRCUIT.

MARYLAND CASUALTY CO.

vs.

PRICE ET AL. (No. 1392.)*

1. ATTORNEY AND CLIENT—ACTIONS FOR NEGLIGENCE—BURDEN OF PROOF.

In a suit against an attorney for negligence, plaintiff must prove the attorney's employment, his neglect of a reasonable duty, and that such negligence resulted in and was the proximate cause of loss to the client.

(For other cases, see Attorney and Client, Cent. Dig. §§ 288, 289; Dec. Dig. § 129[2].)

2. ATTORNEY AND CLIENT—ACTIONS FOR NEGLIGENCE—DECLARATION.

In a suit against an attorney for negligence, the test of the sufficiency of the declaration is whether its allegations, if proved, would make out a case, and, if proof of the facts alleged as to the negligence and resulting loss would establish a cause of action, the declaration is not demurrable.

(For other cases, see Attorney and Client, Cent. Dig. §§ 288, 289; Dec. Dig. § 129[2].)

3. ATTORNEY AND CLIENT—ACTIONS FOR NEGLIGENCE—DECLARATION.

In an action by a liability insurer, the declaration alleged that defendants had been for several years plaintiff's retained attorneys, that plaintiff notified them of an action against a policyholder and directed them to enter an appearance and instructed them to make such defense and take such steps as should be necessary to prevent a judgment, that they neglected to do so and a default judgment was recovered, and that plaintiff attempted to settle the suit, and could have settled it for \$2,000 if the default judgment had not been rendered. *Held*, that while defendants were not advised of any facts constituting a defense, and it was not even alleged that there was a defense or that plaintiff intended to defend on the merits, and the inference was permissible that plaintiff's real purpose was to have a formal appearance or plea entered which would prevent a judgment for a time and enable plaintiff to make an advantageous settlement, the declaration sufficiently showed defendants' employment by plaintiff.

(For other cases, see Attorney and Client, Cent. Dig. §§ 288, 289; Dec. Dig. § 129[2].)

* Decision rendered, Feb. 29, 1916. 231 Fed. Rep. 397.

4. ATTORNEY AND CLIENT—ACTIONS FOR NEGLIGENCE—DECLARATION.

In a liability insurers' action against its attorneys for negligence, the declaration alleged the bringing of an action for injuries against a policyholder, that plaintiff was bound to indemnify the policyholder against loss not exceeding \$5,000 and was bound to defend the suit at its own expense, that it instructed defendants to enter an appearance and make a defense, that it attempted to settle the suit and could have settled it if a default judgment had not been rendered, that defendants failed to enter an appearance or make any defense, and that by reason thereof a judgment for \$15,000 was rendered by default, and that plaintiff was bound to pay the amount thereof. *Held*, that in the absence of any allegation that the policyholder had a defense to the action for injuries, or that the injured person was not justly entitled to recover \$15,000, the declaration stated no cause of action, as it was not shown that if the attorneys had made a proper defense no judgment or a judgment for a less sum would have been recovered, and while it did allege that plaintiff was bound to pay the default judgment, though for more than its limited liability, there was no disclosure of facts showing such liability, and the allegation stated only a conclusion of law.

(For other cases, see Attorney and Client, Cent. Dig. §§ 288, 289; Dec. Dig. § 129[2].)

5. COURTS—UNITED STATES COURTS—JURISDICTIONAL AMOUNT—ALLEGATIONS OF DECLARATION.

Though nominal damages were recoverable for the attorneys' failure to do anything whatever, the declaration nevertheless failed to show that the amount involved gave a Federal court jurisdiction, since, where the pleadings show that there cannot legally be a judgment for an amount necessary to give jurisdiction, jurisdiction cannot attach, though the damages are laid in the declaration at a larger sum.

(For other cases, see Courts, Cent. Dig. § 841; Dec. Dig. § 299.)

6. PLEADING—DECLARATION—CONCLUSIONS OF LAW.

In a liability insurer's action against attorneys, an amended declaration alleged the bringing of an action for injuries against a policyholder, that plaintiff was bound to indemnify the policyholder against loss not exceeding \$5,000 and to defend the suit, that defendants were instructed to appear and defend but neglected to do so and by reason of such neglect a judgment for \$15,000 was rendered by default which plaintiff was bound to and did pay, that defendants knew that plaintiff's liability was limited and that it was obliged to defend the suit, that if they had appeared and made a defense plaintiff's liability would have been only \$5,000, though the judgment against the policyholder might exceed that amount, and that their negligence was the direct cause of loss to plaintiff of the difference between \$5,000 and the amount of the judgment. *Held* that, in the absence of any allegation that the policyholder had a meritorious defense which would have defeated a recovery or reduced the amount of the judgment, the declaration was insufficient, since it did not show that plaintiff was under any obligation to pay in excess of \$5,000, as the allegation that it was compelled to pay the judgment was a mere conclusion of law without any facts to justify it, and it was evident that it was not liable to the policyholder for more than \$5,000 if the policyholder had no meritorious defense.

(For other cases, see Pleading, Cent. Dig. § 13; Dec. Dig. § 8[2].)

7. INSURANCE—LIABILITY INSURANCE—ACTIONS—ELEMENTS OF CAUSE OF ACTION.

The holder of a liability insurance policy, under which the insurer was bound to indemnify the policyholder against loss not exceeding \$5,000 and to defend a suit at its own expense, could not recover more than \$5,000 because of the insurer's failure to defend an action resulting in a default judgment for \$15,000 without alleging and proving a meritorious defense to the action against it.

(For other cases, see Insurance, Cent. Dig. §§ 1599-1602; Dec. Dig. § 635.)

8. ATTORNEY AND CLIENT—ACTIONS FOR NEGLIGENCE—BURDEN OF PROOF.

A liability insurer suing its attorney for negligence in failing to defend an action against a policyholder resulting in a default judgment for \$15,000 had the burden of showing that the party recovering the judgment did not have a valid claim against the policyholder for \$15,000.

(For other cases, see Attorney and Client, Cent. Dig. §§ 288, 289; Dec. Dig. § 129[2].)

9. PLEADING—AMENDMENT OF PLEADING—PERMISSION TO AMEND—STRIKING OUT ALLEGATIONS.

A liability insurer suing its attorneys for negligence in failing to defend an action for injuries against a policyholder alleged that it was bound to indemnify the policyholder against loss not exceeding \$5,000 and to defend the suit, that by reason of the attorneys' negligence a default judgment was rendered for \$15,000, and that it could have settled for no more than \$2,000 if the default judgment had not been rendered. An amended declaration proceeded on the theory that the attorneys' failure to defend made plaintiff liable for the full amount of the default judgment and sought to recover the difference between the amount of the judgment and \$5,000. After the sustaining of a demurrer to the amended declaration, it asked leave to amend further by striking out the averment that it could have settled for not exceeding \$2,000 had the judgment not been rendered. *Held*, that it was not error to refuse to allow this amendment, where it was not shown that the allegation sought to be stricken was inadvertently made, or that it was not in precise accordance with the facts established, as in one aspect of the case the facts averred would defeat a recovery if there was no meritorious defense to the action against the policyholder because the action would not then involve the jurisdictional amount.

(For other cases, see Pleading, Cent. Dig. §§ 676-678, 681-683; Dec. Dig. § 246[1].)

In Error to the District Court of the United States for the Southern District of West Virginia, at Charleston; Benjamin F. Keller, Judge.

Action by the Maryland Casualty Company against George E. Price and others, partners doing business as Price, Smith, Spilman & Clay. Judgment for defendants on demurrer (224 Fed. 271), and plaintiff brings error. Affirmed.

Before Pritchard, Knapp, and Woods, C. JJ.

Clyde B. Johnson, of Charleston, W. Va., and Walter L. Clark, of Baltimore, Md. (Conley & Johnson, of Charleston, W. Va., on the brief), for Plaintiff in Error.

Malcolm Jackson, of Charleston, W. Va. (George E. Price and Buckner Clay, both of Charleston, W. Va., on the brief), for Defendants in Error.

KNAPP, C. J.

The Maryland Casualty Company brings this suit for damages alleged to have resulted from the negligence of defendants as attorneys at law employed by the plaintiff. The averments of the declaration filed January 6, 1915, may be summarized as follows:—

That one Gail V. Lynch brought an action against the Wylie Permanent Camping Company to recover the sum of \$15,000 for personal injuries received by her in August, 1908, while a passenger on one of the camping company's coaches in Yellowstone Park; that under its contract of insurance the plaintiff was bound to indemnify the camping company against any loss suffered by it in such suit, not exceeding \$5,000, and was also bound to defend the suit at its own expense; that the defendants, who had been for several years the retained attorneys of plaintiff, were instructed by it to enter an appearance for the camping company in the suit of Mrs. Lynch, and to make such defense and take such steps as might be needful to prevent a judgment; that the defendants thereupon advised plaintiff that it was not necessary to enter an appearance at rules to avoid a default judgment, but that they would look after the case for the plaintiff and keep it advised in regard thereto; that the plaintiff, relying upon its attorneys to discharge their duty in the premises, attempted to settle the suit of Mrs. Lynch, and could have settled the same for not more than \$2,000, if a default judgment in her favor had not been rendered; that the defendants wholly failed and neglected to enter an appearance or make any plea or defense in the action against the camping company, and that by reason of such neglect a judgment for \$15,000, besides interest and costs, was rendered by default; that under its contract of insurance the plaintiff was bound to and did pay the amount of said judgment, amounting to about \$20,000, and that said judgment would not have been rendered, and plaintiff would not have had to pay the same, except for the negligence of defendants; and that they thereby became indebted to plaintiff in the sum mentioned.

To this declaration a demurrer was interposed which was sustained by the court below, chiefly upon the ground that the declaration failed to allege properly that plaintiff had suffered any damages by reason of the negligence of defendants, and that it was necessary, in order to make out a case, to allege that the camping company had a good defense to Mrs. Lynch's action or allege that a less sum would have been recovered in that action but for the negligence of defendants.

The plaintiff then filed an amended declaration which repeated all the allegations of the original and added averments to the following effect: That the defendants by reason of their former employment knew that the liability of plaintiff under its contract of insurance was limited, and that by the terms of said contract the plaintiff was obligated to defend the Lynch suit; that the

defendants were employed for that purpose; that, if they had appeared for the camping company and made a defense, the extent of the plaintiff's liability would have been only \$5,000, although the judgment against the camping company might exceed that amount; and that the negligent failure of defendants to enter an appearance and defend the Lynch suit was the direct cause of loss to the plaintiff of the difference between \$5,000, its maximum liability under the policy, and the \$20,000 default judgment which it paid.

The defendants demurred to the amended declaration, and this demurrer was sustained by the court for reasons stated in its opinion.

The plaintiff then asked leave to further amend its declaration by striking out the averment that it could have settled the Lynch Case, but for the fact that a default judgment was obtained, for an amount not exceeding \$2,000. The court refused to allow this amendment on the ground that it did not appear that the allegation sought to be stricken out had been inadvertently inserted, and because that allegation was an admission of fact which affected the cause of action and the jurisdiction of the court. These rulings are challenged in the assignments of error.

[1, 2] In a suit against an attorney for negligence, the plaintiff must prove three things in order to recover: (1) The attorney's employment; (2) his neglect of a reasonable duty; and (3) that such negligence resulted in and was the proximate cause of loss to the client. And the test of the sufficiency of the declaration in such a suit is whether its allegations, if proven, would make out a case. In other words, if proof of the facts alleged as to negligence and resulting loss would establish a cause of action, the declaration is not demurrable.

[3] With reference to these requirements, we hold that the fact of employment in this case is sufficiently pleaded, though a word of comment upon the averments in that regard may not be unsuitable. The declaration does not allege that the defendants were employed in this particular case, but that under their general employment they were notified of its pendency and directed to take certain action therein. The averment is this:—

"This plaintiff notified the defendants of the institution and pendency of said action and directed said defendants as attorneys at law for and representing this plaintiff to enter an appearance on behalf of said Wylie Permanent Camping Company, defendant in said action so brought and pending as aforesaid, and instructed its said attorneys, the defendants herein, to make such defense and take such steps as should be necessary to prevent a judgment being rendered therein against said Wylie Permanent Camping Company; and plaintiff says that it became and was the duty of said defendants and each of them to enter an appearance in said action for the said Wylie Permanent Camping Company and do any and all other things of a legal professional character that

were necessary to make up the issue in said action and defend against the judgment therein sought by said Gail V. Lynch."

It will be observed that the defendants are not advised of any facts which would constitute a defense in whole or in part to the suit against the camping company. It is not even stated that there was a defense to the suit, or that the plaintiff intended to defend it on the merits. Indeed, when the declaration is carefully read, and reference is made to what is said about the sum for which the case could have been settled, the inference is certainly permissible that the real purpose of plaintiff was to have a formal appearance or plea entered, which would for the time being prevent a judgment and thus enable plaintiff to effect an advantageous settlement. However, as already said, we do not at all doubt that the declaration sufficiently shows the employment of defendants.

The neglect of a reasonable duty on the part of defendants under their employment is amply alleged, and no question is made as to the sufficiency of the declaration in that regard.

The case then comes to the question whether the averments of the declaration, if proven as set out, would establish that the negligence of defendants resulted in and was the proximate cause of loss to the plaintiff. In other words, does the pleading meet the third requirement above stated by sufficient allegations?

[4] We think it clear that the original declaration does not allege sufficient facts to charge the defendants with liability, because it does not show that plaintiff suffered any damage by reason of their negligence. It is not alleged that if the attorneys had appeared and made a proper defense there would have been no judgment against the camping company, or that the judgment would have been for a less sum. The averment is merely that the default judgment would not have been rendered if defendants had not failed to appear; and the declaration nowhere alleges that the camping company had any defense to the action of Mrs. Lynch, or that she was not justly entitled to recover \$15,000 on account of her injuries. It is true that the declaration alleges that plaintiff under its contract of insurance was bound to and did pay the default judgment. But it does not allege how or why, or under what contract provisions, this obligation was incurred. It merely avers that plaintiff was liable to indemnify the camping company against any loss up to \$5,000, and that it was bound to defend at its own expense the suit of Mrs. Lynch. In short, there is no disclosure of facts on which the liability is predicated, and therefore the averment at most states only a conclusion of law. It follows that the original declaration was properly held to be insufficient because it does not allege that the camping company had a meritorious defense to the Lynch suit, which the defendants negligently failed to interpose, and that she would not have recovered a judgment, or that such judgment would have been for a much less

amount, if the defendants had not failed to discharge the duties of their employment.

[5] We are satisfied that this conclusion is in accord with the weight of authority, although there is some conflict in the reported decisions. Among the cases which sustain the views we have expressed are Harter vs. Morris, 18 Ohio St. 492; Bruce vs. Baxter, 7 Lea (Tenn.) 447; Spangler vs. Sellers (C. C.) 5 Fed. 822; Staples vs. Staples, 85 Va. 76, 7 S. E. 199; Goldzier vs. Poole, 82 Ill. App. 469; Booth vs. McEachen, 181 N. Y. 29, 73 N. E. 488, 2 Ann. Cas. 601; Gabbert vs. Evans, 184 Mo. App. 283, 166 S. W. 635. The rule established by these cases is to the effect that suits against attorneys for negligence are governed by the same principles as apply in other negligent actions. If an attorney, in disregard of his duty, neglects to appear in a suit against his client, with the result that a default judgment is taken, it does not follow that the client has suffered damage, because the judgment may be entirely just, and one that would have been rendered notwithstanding the efforts of the attorney to prevent it. It is said that there is a difference between the case of an attorney who fails to do anything for his client, and one who makes an inexcusable mistake in attempting to comply with instructions; but we do not perceive any basis in principle for such a distinction. In either case the burden is upon the client to prove the damages he has suffered. Some of the cases hold that nominal damages may be recovered if the attorney fails to do anything whatever; but such holding would not avail the plaintiff here, because upon that theory the amount involved would be insufficient to give the court jurisdiction. Vance vs. Vandercook, 170 U. S. 468, 18 Sup. Ct. 645, 42 L. Ed. 1111. In that case the Supreme Court said:—

"In determining from the face of a pleading whether the amount really in dispute is sufficient to confer jurisdiction upon a court of the United States, it is settled that, if from the nature of the case as stated in the pleadings there could not legally be a judgment for an amount necessary to the jurisdiction, jurisdiction cannot attach even though the damages be laid in the declaration at a larger sum. Barry vs. Edmunds, 116 U. S. 550, 560 (6 Sup. Ct. 501, 29 L. Ed. 729); Wilson vs. Daniel, 3 Dall. 401, 407 (1 L. Ed. 655)."

[6] As above stated, the original declaration was held demurable because it did not allege that there was a meritorious defense to the Lynch suit which would have defeated recovery, or reduced the amount of the judgment, if the defendants had not failed to perform their duty. The amended declaration likewise omits these averments, and plaintiff contends that the necessity for making them is avoided by the added allegations of the amendment, the substance of which has been already recited. The contention advanced is set forth in the brief as follows:—

"It must be borne in mind, however, that this suit is not by the defendant against whom the default judgment was rendered, but is

by a casualty company with a limited liability, and the obligation to defend. This is important because it makes it unnecessary to charge that the actual defendant had a good defense to the action in which the default judgment was rendered. The defense which the attorneys were employed to make, if proper skill was used in and attention given thereto, would not affect the liability of the casualty company as to any sum above the \$5,000 maximum liability under the policy."

It will thus be seen that under the amended declaration plaintiff seeks only to recover what it paid out in satisfaction of the default judgment in excess of its contract liability of \$5,000. The right to recover this excess is based on the ground that, if plaintiff had performed its obligation to defend the Lynch suit, the extent of its liability would have been \$5,000, even if there were no defense to that suit; that this obligation to defend was committed to defendants; and that by reason of their neglect the plaintiff suffered damages to the amount of the difference between \$5,000 and the sum actually paid in satisfaction of the default judgment. It is sought in this way to avoid the necessity of proving that there was a meritorious defense to the Lynch suit. Indeed, the plaintiff says in effect that it does not at all matter whether or not there was a defense to that suit, since the defendants knew or should have known the character and extent of its obligation, and are therefore liable for the excess over \$5,000.

We are persuaded that this contention, however plausible, will not bear the test of close examination. The declaration avers that the plaintiff, by virtue of its contract of insurance, was under an absolute liability of \$5,000, and also under a contingent liability arising out of its obligation to defend any suit against the insured. It does not attempt to recover the \$5,000 paid on account of its absolute liability, because for that purpose it would have to show that the judgment would have been for less than \$5,000 if the attorneys had defended the suit. But it says that it would not have been obliged to pay in excess of the \$5,000, which was paid on account of its absolute liability, except for the negligence of defendants, as it was compelled to pay this excess because of the breach of its obligation to defend. But the difficulty is that the declaration fails to allege any facts which show that the plaintiff was under obligation to pay in excess of \$5,000. True, the declaration alleges that by reason of the negligence of defendants the plaintiff breached its contract to defend any suit against the camping company, and that in consequence it was compelled to pay the default judgment. But the allegation that it was compelled to pay the default judgment is clearly a non sequitur, because no facts are stated which show how or why it was compelled to pay that judgment, except the averment that it violated its obligation to defend the suit. This is at best a mere conclusion of law without the disclosure of any facts which justify the conclusion.

It seems evident that the contingent liability of plaintiff for

breach of contract to defend the Lynch suit could not exceed the damages suffered by the camping company because the suit against it was not defended; and manifestly that damage is the difference between the default judgment and the judgment which would have been rendered if the suit had been properly defended. But if there was no defense to that suit, and none of any sort is alleged by the plaintiff, there would be no difference because on that assumption the default judgment is the same as or no greater than the judgment which would have been recovered if defense had been made, and therefore no damage has been suffered by the camping company. If this be a correct analysis of the situation, it follows that the default judgment, so far as it exceeded \$5,000, was paid without legal liability and cannot be recovered from defendants.

[7, 8] This appears from another point of view. If the camping company sued plaintiff to recover the amount of the default judgment, it would have to allege and prove, in order to recover more than \$5,000, substantially the same facts that we think the plaintiff must allege and prove in this action. In either case, it would be necessary to allege and prove a meritorious defense to the Lynch suit. In other words, it comes to the question of which party must assume the burden of proof, and we are constrained to hold that the burden is upon the plaintiff to show that Mrs. Lynch did not have a valid claim against the camping company for \$15,000, and that she would have failed to secure a judgment, or only secured one for a less amount, if her suit had been defended. For this reason we are of opinion that the new averments in the amended declaration do not avoid the necessity of alleging and proving that there was a meritorious defense to the Lynch suit, which if duly interposed would have defeated the action or reduced the judgment, and the amended declaration is therefore demurrable because it does not so allege.

[9] The remaining question needs but a word of comment. We are convinced that the court below did not err in refusing to allow plaintiff to further amend its declaration by striking out the following averment:—

"Plaintiff avers that it could have compromised and settled the claim upon which the said action of Gail V. Lynch against Wylie Permanent Camping Company was instituted by the payment of a sum of money not in excess of \$2,000, up to the time that the default judgment was rendered in said action as hereinafter set forth."

It is not shown that this allegation was inadvertently made, or that it is not in precise accordance with the facts. Moreover, in one aspect of the case, the facts averred would defeat plaintiff's right to recover, if there were no meritorious defense to the Lynch suit, because the jurisdictional amount would not then be involved. The state and federal statutes quoted by plaintiff are clearly designed to prevent injustice on account of formal defects

in pleading, and to permit liberal amendments to cure such defects; and this purpose is emphasized in the authorities cited. We have carefully examined these statutes and decisions and are satisfied that they do not support the plaintiff's contention.

Affirmed.

COURT OF APPEALS OF KENTUCKY.

COLLINS'S EX'RS

vs.

STANDARD ACC. INS. CO.*

1. INSURANCE — NEGLIGENCE — RELATION OF AGENT — CHANGE — IMPUTED NEGLIGENCE.

That the owner of an automobile allowed a guest to give some directions to the chauffeur as to the place they should be carried did not make the chauffeur the agent of the guest instead of the owner, and the chauffeur's negligence was not imputable to the guest, so, in an action by the owner on an accident policy, the guest having been injured and recovered against her, it was no defense that the owner, though obliged to defend action, refused the requests of the insurer to make the defense of imputed negligence.

(For other cases, see Insurance, Cent. Dig. §§ 1530, 1532-1534; Dec. Dig. § 615; Negligence, Cent. Dig. §§ 147, 148; Dec. Dig. § 93[1].)

2. INSURANCE — ACCIDENT INSURANCE — ACTIONS — EVIDENCE — SUFFICIENCY.

Where an accident policy, conditioned to save a motorist harmless from actions from injuries caused by her car, required the motorist to, in good faith, co-operate with the insurer in defending actions, a finding by the jury that the motorist failed to comply with such condition, by failing to set up contributory negligence of a guest of the motorist suing for injuries received in an action against the motorist, *held* warranted by the evidence.

(For other cases, see Insurance, Cent. Dig. §§ 1711-1716; Dec. Dig. § 665[3].)

Appeal from Circuit Court, Jefferson County, Common Pleas, Branch, First Division.

Action by Ruth S. Collins against the Standard Accident Insurance Company. Plaintiff dying, the action was revived in the name of her executors. From a judgment for defendant, plaintiff appeals. Affirmed.

Bennett H. Young, of Louisville, for Appellants.
O'Neal & O'Neal, of Louisville, for Appellee.

SETTLE, J.

This is an appeal from a judgment of the Jefferson circuit court, common pleas branch, First division, entered upon a verdict

* Decision rendered, May 5, 1916. 185 S. W. Rep. 112.

returned for appellee in an action brought against it by Mrs. Ruth S. Collins upon an accident insurance or indemnity policy she obtained of the latter May 2, 1911, whereby, in consideration of the required premium she then paid, i. agreed, subject to certain conditions set forth in the policy, to indemnify her against any loss, not exceeding \$5,000, that might be imposed upon her by law, and paid by her, by way of damages, on account of bodily injuries suffered by any person by reason of her use and operation of a certain automobile owned by her and described in the policy. On February 12, 1912, and during the life of the policy mentioned, Mrs. Collins, while riding in the automobile accompanied by her sister, Miss Sallie Sevier, for the accommodation of the latter caused the chauffeur operating it to stop the machine in front of the Public Library on York street, between Third and Fourth streets, in the city of Louisville. After Miss Sevier had accomplished the object for which the automobile was stopped, it was, at her command or that of Mrs. Collins, again put in motion by the chauffeur. It skidded or by other accidental means so suddenly changed its course as to strike a post at the edge of the pavement. The shock of the collision caused Miss Sevier, who was sitting on the front seat of the machine, to fall therefrom to the ground, thereby causing her to receive, as claimed, certain bodily injuries,, to recover for which she thereafter sued Mrs. Collins, and obtained against her a verdict and judgment for \$730 damages, with interest from May 26, 1913, and costs of the action amounting to \$29.40. Claiming to have paid this judgment to Sallie Sevier, Mrs. Collins, by this action on the policy of indemnity received by her of appellee, sought to recover it of the latter, its resistance of the recovery resulting, as already stated, in the verdict and judgment in its favor. After the motion of Mrs. Collins for a new trial was overruled, and before the filing of the bill of exceptions, she died in Jefferson County, testate, and by an agreed order entered of record the cause was revived in the names of the Fidelity & Columbia Trust Company, executor, and Sallie Sevier, executrix, of her will, who, in their fiduciary capacity, are now prosecuting the appeal.

Clause F of the policy provides:—

"The assured upon the occurrence of an accident shall give immediate written notice thereof with the fullest information obtainable to the company at its home office, Detroit, Michigan, or to its duly authorized agent. He shall give like notice with full particulars of any claim made on account of such accident, and if thereafter any suit, even if groundless, be brought against the assured to recover damages on account of such injuries as are covered by this policy, he shall immediately forward to the company every summons or other process served on him, and the company will, at its own expense, defend against such suit in his name and on his behalf or settle the same."

Clause G provides:—

"The assured shall not voluntarily assume any liability nor settle any claim, except at his own cost, nor incur any expense, nor interfere in any negotiation for settlement or legal proceeding without the consent of the company previously given in writing; but he may provide, at the company's expense, such immediate surgical relief as is imperative at the time of the accident. The assured, when requested by the company, shall aid in effecting settlements, securing evidence, the attendance of witnesses, and in prosecuting appeals."

Clause J provides:—

"No action shall lie against the company to recover for any loss under this policy unless it shall be brought by the assured for loss actually sustained and paid in money by him in satisfaction of a judgment after trial of the issue; nor unless such action is brought within ninety days after final judgment against him has been satisfied."

The legal effect to be given the foregoing provisions of the policy is fully set forth in *Fidelity & Casualty Co. of N. Y. vs. Martin*, 163 Ky. 12, 173 S. W. 307. Appellee's answer admits the issuance of the policy to Mrs. Ruth S. Collins, but denies its liability thereon for the judgment recovered against her by Sallie Sevier, because it, as alleged, was procured by fraud and collusion between Mrs. Collins and Miss Sevier; that although the former notified appellee in writing of the accident, as required by a provision of clause F of the policy such notice did not comply with the further provision thereof, requiring that she furnish full particulars of the accident to and claim of Miss Sevier; that Mrs. Collins also failed to comply with the provision of clause G of the policy, which required her, when requested by appellee, to aid it in securing evidence for use in defense of the action brought against her by Miss Sevier to recover damages on account of her injuries, and likewise failed, as further required by the provision of clause G in question, when requested by appellee to do so, to rely in her answer to the petition in that action upon a plea alleging contributory negligence upon the part of Miss Sevier in the matter of receiving her injuries, or to aid appellee in making defense for her to that action by relying upon the contributory negligence of the plaintiff Sevier. Also that she refused, at appellee's request, to plead certain other facts in her answer, as required by the same provision, which in the opinion of its counsel, if established by the evidence, would have constituted the chauffeur in charge of the automobile at the time of the accident the agent of Miss Sevier. The averments of the answer were controverted by reply.

[1] There was no evidence tending to show that the chauffeur in charge of the machine was the agent of Miss Sevier at the time of the accident. The mere fact that he ran it to the Public

Library and there stopped it, at her request, or that he left the library at her request, did not establish such agency. The machine was owned by Mrs. Collins who was in it with Miss Sevier during the ride of that day. The chauffeur was in Mrs. Collins' employ and subject to her control, which control was not lost by her, nor the relation that the chauffeur sustained as her agent altered, by the request or direction of Miss Sevier that he carry her in the machine to the Public Library, and the acquiescence of Mrs. Collins therein. In view of these facts there is no ground for appellee's contention that the negligence of the chauffeur, alleged to have resulted in the injuries of Miss Sevier, if he was guilty of negligence, should be imputed to her. For these reasons the refusal of Mrs. Collins to rely upon this ground of defense in the answer filed by appellee's attorneys for her to the petition in the action brought by Miss Sevier against her did not constitute a violation of the provision of clause G of the policy, requiring her to aid it in resisting the recovery of damages sought against her in that action. Hence the matter was properly omitted from the instructions given by the trial court to the jury.

[2] There was, however, some evidence tending to show that the refusal of Mrs. Collins to rely upon the plea of contributory negligence contained in the answer originally prepared by her by appellee's counsel to be filed in the action brought against her by Miss Sevier was a violation of the provision of clause G referred to, because there was some evidence of such contributory negligence on the part of Miss Sevier, furnished by the testimony of the chauffeur in charge of the machine and the chauffeur in charge of the automobile of J. B. Camp, an eyewitness of the accident; that of the former being to the effect that at the time of the collision of the machine with the post, which he claimed was caused by the skidding of a wheel thereof on the ice of the street, Miss Sevier was sitting sidewise on the edge of the front seat with her back toward the door, talking to Mrs. Collins, the occupant of the back seat, from which position she was liable to be thrown from the seat and out of the machine by a sudden turn or jar thereof, and that but for the position in which she thus placed herself the collision of the machine with the post would not have thrown her to the ground. This testimony of the chauffeur was, in a large measure, corroborated by that of the chauffeur of the Camp automobile. Though the testimony of the two chauffeurs mentioned was contradicted by the testimony of Miss Sevier and in some sort by the deposition of Mrs. Collins, it furnished some support to appellee's contention that the refusal of Mrs. Collins to permit her answer in the original action to contain a plea of contributory negligence deprived her and appellee of a defense which the latter had a right to make for her in that action.

There was also some evidence conduced to sustain the further

and principal ground of defense presented by appellee's answer in the instant case, namely, that the judgment recovered against Mrs. Collins by Miss Sevier was procured by and through fraud and collusion between them, such evidence being in part circumstantial and in part furnished by the conduct of Mrs. Collins and Miss Sevier, the testimony of the former and other witnesses, and as a whole manifesting, as contended by appellee, the facts: (1) That Mrs. Collins, in notifying it and, later, its counsel of the accident, claim, and action of Miss Sevier, falsely represented that there were no witnesses to the accident known to her other than Miss Sevier and herself, when she knew that the accident was witnessed by her chauffeur and the chauffeur of J. B. Camp, the latter having lifted Miss Sevier from the street and placed her in the automobile immediately following its collision with the post; (2) that in giving such notice, first to appellee and then to its counsel, she suppressed information of the fact that Miss Sevier was her sister, and, at the time of the accident and for several years prior thereto resided with her as a member of her family, and falsely represented that Miss Sevier's residence was either in St. Louis, Mo., or Memphis, Tenn.; (3) that Mrs. Collins never informed appellee or its counsel of the relationship of Miss Sevier to her, or that she was an inmate of her home, until her deposition was given in the action of Miss Sevier against her; (4) that Mrs. Collins failed and refused to render appellee or its counsel any assistance in finding or securing evidence for use upon the trial of the action of Miss Sevier against her, and refused to make such defense in that action as appellee's counsel advised her would be authorized by the law and facts connected with and surrounding the accident; (5) that Mrs. Collins gave assistance to Miss Sevier in the action brought by the latter against her, by carrying her in her automobile to the office of her attorney during the latter's preparation of the case for trial, carrying her and some of her witnessess to and from the courthouse during the trial, and, on one occasion during the trial, taking Miss Sevier and her witnesses to a restaurant for luncheon and returning them to the courthouse; (6) that although Mrs. Collins, after the institution of the action against her by Miss Sevier, went at the request of appellee's counsel to their office to be advised with as to the defense necessary therein, she declined to make any statement to them, or to be governed by their advice in respect thereto, and after the interview went from their office in her automobile to that of Miss Sevier's counsel, and carried the latter therefrom to her home. It was not the province of the trial court to determine, nor are we called upon to say, whether the evidence tending to prove the foregoing facts and circumstances satisfactorily establish the fraud and collusion charged against Mrs. Collins and Miss Sevier. It was only the duty of that court to determine, and of this court to declare, whether the evidence

authorized the submission of the issue as to the fraud and collusion to the decision of the jury, and as, in our opinion, it was sufficient for that purpose, and we are unable to say the verdict is unsupported by evidence, or is flagrantly against the evidence, we are without authority to disturb it, in the absence of error appearing in some ruling of the trial court, and no such error is disclosed by the record.

The two instructions given by the trial court, with becoming brevity, correctly submitted the issues of fact necessary to be determined by the jury; and, the record as a whole disclosing no ground for a reversal, the judgment is affirmed.

POLSTEIN *vs.* GENERAL ACC., FIRE & LIFE ASSUR. CORP.*

(Supreme Court of New York, Appellate Division, First Department.)

INSURANCE—BURGLARY INSURANCE—ACTIONS—EVIDENCE —SUFFICIENCY.

In an action on an insurance policy, where the condition of liability was proof of larceny, proof of a loss of jewelry, where the circumstances did not show the method of loss or inhibit an inference of misplacement, etc., will not warrant a judgment against the insurer.

(For other cases, see Insurance, Cent. Dig. § 1722; Dec. Dig. § 665[4].)

Appeal from City Court of New York.

Action by Isaac Polstein against the General Accident, Fire & Life Assurance Corporation. From a judgment for defendant, plaintiff appeals. Determination and judgment affirmed.

See, also, 90 Misc. Rep. 3, 152 N. Y. Supp. 906, 157 N. Y. Supp. 1142.

The opinion by Judge McAvoy, in the City Court, follows:—

"The condition of liability is the proof of larceny. Without its occurrence no predicate of damage can arise. Proof of persuasive nature must be given of every fact essential to the judgment or finding of a larcenous taking. Proof means evidence consisting of a direct communication of knowledge acquired through the senses of the happening of the fact itself, or evidence of a combination of facts called circumstances, from which the fact required to be established is necessarily inferred. It is a judicial postulate that inference must be legitimately derived from the proven circumstantial facts and follow their establishment to the extent of at least moral certainty. All possible error is, of course, not excluded in any human mode of trial of facts. A doubt should not survive the proof, in the sense of doubt as to where the greater weight of evidence lies. Here a conclusion ought not to have been reached that the proof of circumstances justified the inference of a caption and asportation. A loss of the jewelry is undoubtedly. The method is not proven. The circumstances do not inhibit a misplacement, or other disposal not

* Decision rendered, April 28, 1916. 158 N. Y. Supp. 868.

recalled. For this lack I must hold the verdict unauthorized, and, upon the reservation at the trial, direct a verdict for the defendant."

Argued before Clarke, P. J., and McLaughlin, Laughlin, Scott, Dowling, Smith, Davis, and Page, JJ.

C. Goldzier, of New York City, for Appellant.
J. L. Prager, of New York City, for Respondent.

THIRD NAT. BANK OF COLUMBUS *vs.* FIDELITY &
DEPOSIT CO. OF MARYLAND. (No. 360.)*

(Supreme Court of Georgia.)

INSURANCE—ACTIONS—CONTRACT LIMITATION.

Where a fidelity company entered into a bond to indemnify a bank against loss which it might incur through the dishonesty of a named employee or through any act of omission or commission on his part done or omitted in bad faith in the performance of any duty or trust assigned to him, and among the stipulations and conditions of the bond were that there should be no liability on the part of the company unless the act of default causing loss occurred before the expiration of the bond or of its continuance, and unless such loss should be discovered during such designated term or within one year after the expiration thereof, and that claim for loss should be made promptly after knowledge thereof, and that no suit should be maintained on the bond unless commenced within one year from the time of making claim thereon, the company was not liable for losses incurred in consequence of the default and dishonesty of the employee which were not discovered until more than nine years after the expiration of the bond and its continuances, although claim was then made promptly therefor and action upon the bond brought at once.

(For other cases, see Insurance, Cent. Dig. § 1546; Dec. Dig. § 622[3].)

Error from Superior Court, Muscogee County; S. P. Gilbert, Judge. Action by the Third National Bank of Columbus against the Fidelity & Deposit Company of Maryland. Judgment for defendant, and plaintiff brings error. Affirmed.

F. U. Garrard and A. S. Bradley, both of Columbus, for Plaintiff in Error.

A. W. Cozart, of Columbus, for Defendant in Error.

* Decision rendered, April 14, 1916. 88 S. E. Rep. 584. Syllabus by the Court.

**THIRD NAT. BANK OF COLUMBUS vs. AMERICAN
BONDING CO. OF BALTIMORE. (No. 370.)***

(Supreme Court of Georgia.)

1. INSURANCE—ACTIONS—CONTRACT LIMITATION.

Where a fidelity company enters into a bond to indemnify a bank against loss which it may incur through the dishonesty or fraud of an employee for a designated term, and the bond contains a stipulation that "no suit or proceeding at law or in equity shall be brought after 365 days shall have passed from the date upon which the surety's responsibility for the further acts of the employee ceased," a suit based upon a claim for default of the employee cannot be maintained by the obligee, if brought more than 365 days after the expiration of the term covered by the bond; and the fact that a default is not discovered by the obligee or its officers until the lapse of more than one year from the expiration of the term of the bond and its continuance will not have the effect of extending the time within which suit may be brought. *John Church Co. vs. Aetna Indemnity Co.*, 13 Ga, App. 826, 80 S. E. 1093; *Brown vs. Savannah Mutual Insurance Co.*, 24 Ga. 97; *Melson vs. Phenix Insurance Co.*, 97 Ga., 722, 25 S. E. 189; *Mass. Benefit Life Ass'n vs. Robinson*, 104 Ga. 256, 30 S. E. 918, 42 L. R. A. 261. See, also, *Third National Bank vs. Fidelity & Deposit Co.*, 88 S. E. 584, this day decided.

(For other cases, see *Insurance. Cent. Dig.* § 1546; *Dec. Dig.* § 622[3].)

Error from Superior Court, Muscogee County; S. P. Gilbert, Judge. Action by the Third National Bank of Columbus against the American Bonding Company of Baltimore. Judgment for defendant, and plaintiff brings error. Affirmed.

F. U. Garrard and A. S. Bradley, both of Columbus, for Plaintiff in Error.

A. W. Cozart, of Columbus, for Defendant in Error.

* Decision rendered, April 15, 1916. 88 S. E. Rep. 585. Syllabus by the Court.



McCRARY ET AL. vs. FARMERS' MUT. INS. CO.

(No. 11377.)*

(Kansas City Court of Appeals. Missouri.)

1. INSURANCE—LIGHTNING INSURANCE—ACTIONS—POLICY.

A policy insuring animals against lightning provided that live stock might be insured by the class, or an animal might be specifically described, and that when stock was insured by the class, the insured should receive such a proportion of the loss sustained as the total value of the stock in that class should bear to the amount of his insurance

* Decision rendered, Feb. 21, 1916. 183 S. W. Rep. 669.

on that class. It was also provided that in no case should the insured receive more than the cash value of any animal. Insured, who owned six head of cattle, including a bull, gave evidence of the value of all but the bull. *Held*, that as the cattle were insured in a class, and only one of the cows was killed, the evidence did not justify recovery, for until the value of the entire herd was established, there was no standard for computing the loss which should be based on the proportion, the value of the herd bore to the insurance on the cattle.

(For other cases, see Insurance, Cent. Dig. § 1722; Dec. Dig. § 665[4].)

Appeal from Circuit Court, Daviess County; Arch B. Davis, Judge.
"Not to be officially published."

Action by J. M. McCrary and others against the Farmers' Mutual Insurance Company. From a judgment for plaintiffs, defendant appeals. Reversed and remanded.

Dudley & Selby and Nat G. Cruzen, all of Gallatin, for Appellant.
Leopard & Fair, of Gallatin, for Respondents.



GUERINGER *vs.* FIDELITY & DEPOSIT CO. OF MARYLAND.

(No. 11850.)*

(Kansas City Court of Appeals. Missouri.)

1. INSURANCE—BURGLARY INSURANCE—NOTICE AND PROOFS OF LOSS—SUFFICIENCY OF EVIDENCE.

In an action on a policy of burglary insurance, evidence *held* to show that notice and proofs of loss were given the insurer.

(For other cases, see Insurance, Cent. Dig. §§ 1723, 1724, 1726, 1727; Dec. Dig. § 665[7].)

2. INSURANCE—BURGLARY INSURANCE—KEEPING OF BOOKS BY INSURED.

A book wherein the owner of a pool hall entered the amounts of money taken in, amounts paid out, and the amounts placed in the safe each day, was a compliance with his policy of burglary insurance requiring him to keep books showing the money on hand to enable the insurer to determine a loss.

(For other cases, see Insurance, Cent. Dig. § 853; Dec. Dig. § 335[3].)

4. INSURANCE—BURGLARY INSURANCE—ACTION—INSTRUCTION.

In an action on a policy of burglary insurance on money in insured's safe, an instruction that if the jury found from the evidence that money belonging to plaintiff was stolen from the safe and taken and carried away, and if they further found that same was lost to the plaintiff, referring thereafter to "such loss," was not erroneous as misleading the jury or authorizing them to include in their verdict the loss of uninsured watches and jewelry in insured's safe.

(For other cases, see Insurance, Cent. Dig. § 1780; Dec. Dig. § 669[12].)

* Decision rendered, April 3, 1916. 184 S. W. Rep. 936.

5. INSURANCE—BURGLARY INSURANCE—INCREASE OF HAZARD.

Where the local agent who solicited a burglary insurance policy was a frequenter of insured's pool hall where a handbook was run, a method of gambling on horse races, and where card games were played for brass checks, good for merchandise, a practice in operation when the policy was taken out, the policy was not invalid as for an increase of hazard after its issuance.

6. INSURANCE—LOSS—NONPAYMENT—PENALTY—BURGLARY INSURANCE.

In an action on a policy of burglary insurance covering money in the safe in insured's pool hall, where there were facts disclosed after loss tending to throw suspicion on insured's claim that he had money in the safe at the time of the burglary, or at least that he had anything like the sum he claimed, while he claimed the amount of the policy as his loss, his suit being for such amount, but his evidence and the jury's finding for much less, the insurer was not liable for the penalty for vexatious delay and for an attorney's fee, having the right under the circumstances to require plaintiff to establish the proof of his loss and the extent thereof in court.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

7. INSURANCE—VEXATIOUS DELAY—QUESTION FOR JURY.

The question of vexatious refusal to pay a policy of insurance is ordinarily a question of fact for the jury.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

Appeal from Circuit Court, Jackson County; Frank G. Johnson, Judge.

"Not to be officially published."

Suit by Vic Gueringer against the Fidelity & Deposit Company of Maryland. From a judgment for plaintiff, defendant appeals. Judgment affirmed conditionally upon filing of a remittitur; otherwise reversed, and case remanded.

Lathrop, Morrow, Fox & Moore, Geo. J. Mersereau, and Hugh E. Martin, all of Kansas City, for Appellant.

Handy & Swearingen, of Kansas City, for Respondent.

**GOLDMAN vs. NEW JERSEY FIDELITY & PLATE GLASS
INS. CO. (No. 11856).***

(Kansas City Court of Appeals. Missouri.)

**INSURANCE—BURGLARY INSURANCE—ACTIONS—EVIDENCE
—QUESTION FOR JURY.**

Evidence held to sustain the allegations of the petition, seeking recovery under a policy of burglary insurance, that a safe was broken into with tools in the specific manner required by the policy for the at-

* Decision rendered, Feb. 21, 1916. 183 S. W. Rep. 709.

taching of the insurance company's liability, so as to require submission of that issue to the jury.
 (For other cases, see Insurance, Cent. Dig. §§ 1744, 1762; Dec. Dig. § 668[10.])

Appeal from Circuit Court, Jackson County; Daniel E. Bird, Judge.
 "Not to be officially published."

Action by C. Goldman against the New Jersey Fidelity & Plate Glass Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Ed E. Yates, of Kansas City, for Appellant.
 Harry Friedberg, of Kansas City, for Respondent.

JUCKETT ET AL. *vs.* BRENNAMAN ET AL. (No. 18790.)*
 (Supreme Court of Nebraska.)

3. INSURANCE—COMPANIES—ACTIONS—SERVICE OF PROCESS.

In an action against an incorporated insurance company in a county where there is an agency, the service may be upon the chief officer of such agency. Rev. St. 1913, § 7635

(For other cases, see Insurance, Cent. Dig. § 1572; Dec. Dig. § 626.)

Appeal from District Court, Madison County; Welch, Judge.

Action by Bessie Jucket and others against Sam Brennaman and others. From a judgment for plaintiffs, defendants appeal. Affirmed.

Willis E. Reed, of Madison, M. A. Hall, of Omaha, and Cain & Mapes, of Schuyler, for Appellants.
 Kelsey & Rice, of Norfolk, for Appellees.

* Decision rendered, April 29, 1916. 157 N. W. Rep. 925. Syllabus by the Court.

MARYLAND CASUALTY CO. *vs.* PEPPARD ET AL.
 (No. 7171.)*

(Supreme Court of Oklahoma.)

2. INSURANCE—EMPLOYERS' LIABILITY INSURANCE—EXTENT OF LIABILITY.

Agreed statement of facts and record examined, and held: That they do not disclose whether the person injured was a "direct employee" of

* Decision rendered, Dec. 7, 1915. Rehearing denied, May 2, 1916. 157 Pac. Rep. 106. Syllabus by the Court.

the assured within the meaning of that term as used in another casualty insurance policy wherein the company agrees to indemnify the assured against liability on account of bodily injuries accidentally suffered by any person other than direct employees of the assured, and which further provides that: "This policy does not cover any accident to, or caused by, any direct employee of the assured."

(For other cases, see Insurance, Dec. Dig. § 512.)

3. INSURANCE—EMPLOYERS' LIABILITY INSURANCE—EXTENT OF LIABILITY.

Such policy further provided: "The company's liability for loss from an accident resulting in bodily injuries, including death resulting therefrom, to one person is limited to five thousand dollars (\$5,000.00), and, subject to the same limit for each person, the company's total liability for loss from an accident resulting in bodily injuries, including death resulting therefrom, to more than one person is limited to ten thousand dollars (\$10,000.00). In addition to these limits, the company will, at its own cost (court costs and all interest accruing after entry of judgment upon such part thereof as shall not be in excess of the limits of the company's liability as hereinbefore expressed being considered part thereof), investigate all accidents and defend all suits, even if groundless, of which notices are given to it as hereinafter required, unless the company shall elect to settle the claim or suit."

Held, that the \$5,000 limitation does not include interest and the costs and expenses of the original action prosecuted or defended by the company pursuant to the terms of the policy, and that upon recovery of a larger sum by the plaintiff therein the company, in addition to such limit, is liable for such court costs and all interest accruing upon such part of said judgment as is not in excess of said \$5,000 limitation.

(For other cases, see Insurance, Dec. Dig. § 513.)

Error from District Court, Oklahoma County; Edward Dewes Oldfield, Judge.

Action by Onno Peppard against the Oklahoma City Construction Company and another, as defendants, and the Maryland Casualty Company, as garnishee. Judgment for plaintiff, and the garnishee brings error. Modified, and cause remanded, with instructions.

Jas. S. Ross and L. D. Threlkeld, both of Oklahoma City, for Plaintiff in Error.

Harris, Nowlin & Singleton, of Oklahoma City, for Defendant in Error Peppard.

FIDELITY & CASUALTY CO. *vs.* TYLER COTTON OIL COMPANY. (No. 1514)*

(Court of Civil Appeal of Texas. Texarkana.)

1. INSURANCE—EMPLOYER'S LIABILITY INSURANCE—PAYMENT OF PREMIUMS—SUFFICIENCY OF EVIDENCE.

In suit by an employer's liability insurer for a premium, evidence held sufficient to support the finding of the trial court that defendant

* Decision rendered, Feb. 24, 1916. 184 S. W. Rep. 304.

rendered the insurer true statements of its pay roll in compliance with the terms of its policies and that defendant had paid all premiums due from it under the policies.

(For other cases, see Insurance, Cent. Dig. §§ 245, 404, 405; Dec. Dig. § 188[2].)

2. INSURANCE—EMPLOYER'S LIABILITY INSURANCE.—LIABILITY FOR PREMIUMS.

Where an employer's liability policy provided that the premium to be paid should be based on the entire compensation of which an estimate was given in the schedule, also expressly providing that it did not cover indemnity to the assured for injury or death suffered by any reason "unless his compensation is included in the estimate set forth in the schedule," the fact that the assured failed to include the salaries of its manager and bookkeeper in its report of compensation paid did not entitle the insurer to recover premiums based thereon, since there was no failure on the part of the assured to pay premium if the salaries of such employees did not go in the labor record and were not in the estimated compensation given in the schedule as found.

(For other cases, see Insurance, Cent. Dig. § 394; Dec. Dig. § 183.)

Appeal from Smith County Court; Jesse F. Odom, Judge.

Suit by the Fidelity & Casualty Company against the Tyler Cotton Oil Company. From a judgment for defendant, plaintiff appeals. Affirmed.

J. A. Bulloch and B. C. Johnson, both of Tyler, for Appellant.
Simpson, Lasseter & Gentry, of Tyler, for Appellee.

UNITED STATES FIDELITY & GUARANTY CO. vs. PRESSLER. (No. 1563.)*

(Court of Civil Appeals of Texas. Texarkana.)

1. INSURANCE—CASUALTY INSURANCE—"IMMEDIATE" NOTICE.

Under Rev. Civ. St. art. 5714, providing that no stipulation in any contract requiring notice to be given of any claim for damages as a condition precedent to the right to sue thereon shall be valid unless reasonable, construed as not including a stipulation regarding the occurrence of an accident insured against and as limited to claims forming the basis of a suit for damages, the provision of a policy of casualty insurance, requiring insured to give immediate written notice of an accident, was satisfied by notice on October 25th of an accident on October 9th, the word "immediate" meaning without any time intervening, without any delay, present, instant, and covering notice with due diligence under the circumstances of the case and without any unnecessary and unreasonable delay.

(For other cases, see Insurance, Cent. Dig. § 1329; Dec. Dig. § 539[3].)

(For other definitions, see Words and Phrases, First and Second Series, *Immediate.*)

* Decision rendered, March 29, 1916. Rehearing denied, April 13, 1916. 185 S. W. Rep. 326.

2. INSURANCE—CASUALTY INSURANCE—JUDGMENT AGAINST INSURED—COLLUSION—EVIDENCE.

Evidence, in a contractor's action on a policy of casualty insurance, to recover the amount paid an employee, held to show that the judgment in favor of the employee against the insured was not the result of collusion and fraud.

(For other cases, see Insurance, Cent. Dig. §§ 1555, 1722; Dec. Dig. § 665[4].)

3. INSURANCE—CASUALTY INSURANCE—DISCLAIMER OF LIABILITY—EFFECT.

Where the insurer, having notice of an accident to the insured's employee, disclaims any liability and refuses to make any defense, it cannot, in thereafter defending an action by the insured, complain that the insured has made a reasonable and just settlement with the injured party, and this is so though the policy provides against compromising claims without the insurer's written consent, and that no action shall lie against the insurer for loss under the policy unless brought for reimbursement of money actually paid on a judgment.

(For other cases, see Insurance, Cent. Dig. § 1298; Dec. Dig. § 514.)

Appeal from District Court, Cherokee County; L. D. Guinn, Judge. Action by Joe M. Pressler against the United States Fidelity & Guaranty Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Hunt, Myer & Teagle, of Houston, and John C. Box, of Jacksonville, for Appellant.

Lee G. Carter, of Jacksonville, Norman, Shook & Gibson, of Rusk, and W. J. Townsend, Jr., of Jacksonville, for Appellee.

**SHAFER ET AL. vs. UNITED STATES CASUALTY CO.
(No. 13189.)***

(Supreme Court of Washington.)

1. INSURANCE—INDEMNITY—NECESSITY OF NOTICE—IMPOSSIBILITY.

Where, because of circumstances, it is impossible to give the insurer notice of an accident insured against within the time specified in the policy, failure to notify is excused and notice within a reasonable time after removal of the obstacle is sufficient.

(For other cases, see Insurance, Cent. Dig. § 1334; Dec. Dig. § 539[6].)

2. INSURANCE—INDEMNITY—POLICY—CONSTRUCTION—CONDITIONS PRECEDENT TO LIABILITY—NOTICE.

An indemnity policy, requiring the insured to give notice of all accidents and claims therefor at the insurer's home office, and requiring all possible co-operation with the insurer, does not make such notice a condition precedent to recovery under the policy, or even of the essence of the contract.

(For other cases, see Insurance, Cent. Dig. § 1521; Dec. Dig. § 612[2].)

3. INSURANCE—NOTICE OF LOSS—MAILING LETTER.

Testimony that the witness sent two letters, return addressed, to one insured, under an indemnity policy, containing notice of an accident in his elevator, and that they were not returned, is insufficient to show notice in opposition to positive testimony that they were not received. (For other cases, see Insurance, Cent. Dig. §§ 1723, 1724, 1726, 1727; Dec. Dig. § 665[7].)

4. INSURANCE—INDEMNITY—NOTICE TO INSURED—EVIDENCE—SUFFICIENCY.

Evidence *held* to show that an insured had no notice of an accident covered by his indemnity policy until institution of suit therefor, by one injured in his elevator, so as to excuse his failure to notify the insurer prior to such suit.

(For other cases, see Insurance, Cent. Dig. §§ 1723, 1724, 1726, 1727; Dec. Dig. § 665[7].)

5. INSURANCE—ACTIONS—AMOUNT OF RECOVERY—COSTS.

Under an indemnity policy, requiring the insurer to defend actions covered by it, allowance of costs, attorney's fees, and witness and reporting fees to the insured, who sued on a breach of the policy, is proper.

(For other cases, see Insurance, Cent. Dig. §§ 1805, 1806; Dec. Dig. § 675.)

Department 2. Appeal from Superior Court, King County; Mason Irwin, Judge.

Action by Julius Shafer and another, doing business under the firm name and style of Shafer Bros., against the United States Casualty Company. Judgment for plaintiffs, and defendant appeals. Affirmed.

Kerr & McCord, of Seattle, for Appellant.
Vince H. Faben, of Seattle, for Respondents.

* Decision rendered, April 21, 1916. 156 Pac. Rep. 861.

LIFE.**UNITED STATES CIRCUIT COURT OF APPEALS.
SECOND CIRCUIT.**

IN RE ARKIN ET AL.

APPEAL OF GOIDEL. (No. 186.)*

BANKRUPTCY—PROPERTY PASSING TO TRUSTEE—LIFE INSURANCE POLICY.

The trustee in bankruptcy cannot compel the surrender of an insurance policy on the life of the bankrupt, which had a cash value, but which he testified was the property of his wife, who was sole beneficiary, and who paid the premiums, even though the bankrupt had power to change the beneficiary.

(For other cases, see Bankruptcy, Cent. Dig. § 201; Dec. Dig. § 143[12].)

Appeal from the District Court of the United States for the Southern District of New York.

In the matter of Louis Arkin and J. Lionel Guild, individually and as copartners composing the firm of Arkin & Guild, bankrupts. From an order of the District Court, reversing an order of the referee which directed the surrender of a policy of life insurance upon the life of one of the bankrupts, Harry A. Goidel, as trustee in bankruptcy, appeals. Affirmed.

On appeal by the trustee in bankruptcy from an order of the District Court for the Southern District of New York which reversed an order of the referee which directed the surrender of a policy of insurance issued by the Metropolitan Life Insurance Company upon the life of the bankrupt Guild.

Before Coxe, Ward, and Rogers, C. JJ.

Eugene L. Bondy, of New York City, for Appellant.
Benjamin Frindel, of New York City, for Appellee.

COXE, C. J.

The question here is whether the bankrupt's wife or his trustee in bankruptcy is entitled to a policy of insurance on his life. The referee directed the bankrupt to turn over the policy to his trustee in bankruptcy. The District Judge reversed this decision upon the authority of the Hammel Case, 221 Fed. 56, 137 C. C. A. 80, and Burlingham vs. Crouse, 181 Fed. 479, 104 C. C. A. 227, affirmed 228 U. S. 459, 33 Sup. Ct. 564, 57 L. Ed. 920, 46 L. R. A. (N. S.) 148. The question is an interesting one, but in view of the bankrupt's testimony that the policy was the property of his wife, she being the sole beneficiary and having paid the premiums, we think any doubt should be resolved in her favor.

In principle the case at bar cannot be distinguished from the

* Decision rendered, March 14, 1916. 231 Fed. Rep. 947.

Hammel Case; in one case the policy had a cash surrender value and in the other a loan value, but the language of the court is equally applicable to the case at bar. At page 58 of 221 Fed., at page 82 of 137 C. C. A., Judge Lacombe says:—

"The proposition that he should be constrained against his will, by an order enforceable by imprisonment in the event of disobedience, to deprive his wife of her present interest in the policy, to make himself the beneficiary, to borrow two-thirds of the \$3,000 from the company, and turn it over to his creditors, and then to make her again the beneficiary of the remaining third, seems contrary to public policy and to good morals."

The order is affirmed.



UNITED STATES DISTRICT COURT.

E. D. LOUISIANA.

IN RE BONVILLAIN. (No. 2054.)*

1. BANKRUPTCY—POWERS OF TRUSTEE—EXEMPTIONS.

While a trustee in bankruptcy cannot arbitrarily refuse to set aside an exemption to which the bankrupt is entitled, he has discretion, and represents all the creditors, and may in a proper case himself raise the question of the bankrupt's right to a claimed exemption.

(For other cases, see Bankruptcy, Cent. Dig. §§ 671, 673; Dec. Dig. § 400[1].)

2. BANKRUPTCY—PROPERTY PASSING TO TRUSTEE—LIFE INSURANCE POLICY.

Life insurance policies, originally payable to the insured or his estate, but later assigned to his wife, with full reservation of right to change the beneficiary at will, and which had cash surrender values at the time of the bankruptcy of the insured, pass to the trustee, unless exempt.

(For other cases, see Bankruptcy, Cent. Dig. § 201; Dec. Dig. § 143[12].)

3. EXEMPTION—STATUTE—RETROACTIVE OPERATION.

Act La. No. 189 of 1914, exempting the proceeds of life insurance policies from execution for debts, could not constitutionally be given retroactive effect, so as to exempt life insurance policies which could have been seized by creditors whose claims originate prior to the enactment of that statute.

(For other cases, see Exemptions, Cent. Dig. § 75; Dec. Dig. § 50[1].)

4. BANKRUPTCY—EXEMPTIONS—PROPERTY PASSING TO TRUSTEE—LIFE INSURANCE POLICY.

Prior to the enactment of Act. La. No. 189 of 1914, exempting the proceeds of policies on the life of a bankrupt of which his wife was beneficiary, one which gave the insured the power to change the beneficiary, and which had a cash surrender value, could, under Civ. Code

* Decision rendered, April 5, 1916. 232 Fed. Rep. 370.

La. art. 3183, making all the property of a debtor the common pledge of his creditors, and Code Prac. La. art. 647, providing that an incorporeal right might be seized under execution, be seized under execution, and therefore passed to the trustee in bankruptcy.

(For other cases, see Bankruptcy, Cent. Dig. § 201; Dec. Dig. § 143[12]; Exemptions, Cent. Dig. § 75; Dec. Dig. § 50[1].)

In Bankruptcy. In the matter of Arthur A. Bonvillain, bankrupt. On an application by the bankrupt for a review of an order of the referee declining to set aside as exempt certain policies on the life of the bankrupt surrendered by him to the trustee. Order affirmed.

Borah, Himel & Bloch, of Franklin, La., for Bankrupt.

FOSTER, D. J.

In this matter the bankrupt surrendered certain policies of life insurance, but claimed them as exempt by virtue of Bankr. Act July 1, 1898, c. 541, § 6, 30 Stat. 548 (Comp. St. 1913, § 9590), and the law of Louisiana (Act 189, adopted July 9, 1914). The trustee declined to set aside the policies as exempt, and the bankrupt applied to the referee for an order to compel him to do so. The referee, however, approved the action of the trustee, on the ground that Act 189 of 1914 is unconstitutional with regard to debts existing before its passage, and therefore without application to the said policies. It is this order that is asked to be reviewed.

[1] The bankrupt contends that the trustee is without discretion, and is obliged to set aside and make a report of all property claimed as exempt, leaving it to the creditors to except to the report, if so minded, and hence that the trustee should be ordered to allow the exception. This is entirely too technical a view to take of the matter. The trustee could not arbitrarily refuse to set aside property to which the bankrupt was clearly entitled by law; but he represents all of the creditors, and is vested with some discretion. In a proper case questions regarding the bankrupt's right to exemptions may as well be raised by the trustee as by the creditor, and it is immaterial how this is done, provided all parties have their day in court.

[2] There is no dispute as to the facts. Bonvillain was adjudicated a bankrupt on July 28, 1915. He scheduled unsecured debts amounting to over \$47,000 and no assets, except the policies in question, which at the date of the adjudication had net cash surrender values of about \$4,000. All of the debts scheduled had matured before the passage of Act 189 of 1914. The policies had all been in existence at least 15 years. They were originally payable to Bonvillain, the insured, or his estate, but some years before bankruptcy had been assigned by him to his wife, with full reservation of his right to change the beneficiary at will. Undoubtedly the policies are such as would pass to the trustee, unless exempt. *In re Herr* (D. C.) 182 Fed. 716; *in re Jamison Bros.* (D. C.) 222 Fed. 93; *in re Shoemaker* (D. C.) 225 Fed. 330;

Hiscock vs. Mertens, 205 U. S. 202, 27 Sup. Ct. 488, 51 L. Ed. 771.

[3] And while it may be conceded Act. 189 of 1914 is valid, and not in conflict with either the state or federal Constitutions (Holden vs. Stratton, 198 U. S. 202, 25 Sup. Ct. 656, 49 L. Ed. 1018), it could not be, and was not intended to be, retroactive. Therefore, if the ordinary creditors could have looked to the policies for the payment of their debts, the act would have no effect as to them. Louisiana Constitutions, 1898 and 1913, art. 245; Lloyd vs. Hamilton, 52 La. Ann. 861, 27 South. 275; Blouin vs. Ledet, 109 La. 711, 33 South. 741; Taylor vs. Saloy, 38 La. Ann. 65; Martin vs. Kirkpatrick, 30 La. Ann. 1214; Sturges vs. Crowninshield, 4 Wheat. 122, 4 L. Ed. 529; Gunn vs. Barry, 15 Wall. 610, 21 L. Ed. 212; Edwards vs. Kearzey, 96 U. S. 595, 24 L. Ed. 793.

[4] Could the creditors of the bankrupt have realized on these particular policies by execution or otherwise. The solution of the question depends on the law of Louisiana. Nichol vs. Levy, 5 Wall. 433, 18 L. Ed. 596. There are no Louisiana decisions directly in point, and very few from other jurisdictions. Policies of life insurance are, however, by the modern jurisprudence, treated as property, though of a peculiar kind, and as choses in action, which, though not subject to execution at common law and in the absence of a statute, may be reached in equity by creditors. Kratzenstein vs. Lehman, 18 Misc. Rep. 590, 42 N. Y. Supp. 237; Rice vs. Smith, 72 Miss. 42, 16 South. 417; Biggert vs. Straub, 193 Mass. 77, 78 N. E. 770, 118 Am. St. Rep. 449; Heilbron's Estate, 14 Wash. 536, 45 Pac. 153, 35 L. R. A. 602; Skinner vs. Holt, 9 S. D. 427, 69 N. W. 595, 62 Am. St. Rep. 878; Burlingham vs. Crouse, 228 U. S. 459, 33 Sup. Ct. 564, 57 L. Ed. 920, 46 L. R. A. (N. S.) 148.

With regard to the policies herein claimed it will be noted they are at present payable to the wife. By an unbroken line of decisions in Louisiana it is settled that an ordinary policy of life insurance payable to the wife is her separate property, not subject to the community debts, and unassignable without her consent. See Succession of Emonot, 109 La. at page 365, 33 South. 368. But the Supreme Court of Louisiana also recognizes the general rule that a policy is a chose in action and assignable (Lake vs. New York Life Ins. Co., 120 La. 974, 45 South. 959), and that, where the husband reserves the right to change the beneficiary at will, the wife had no vested interest in the policy, and may be disregarded, and the policy assigned without her consent (Alba vs. Provident Savings Life Ins. Co., 118 La. 1021, 43 South. 663).

Under the law of Louisiana all the property of a debtor is the common pledge of his creditors (Civil Code, art. 3183), and an incorporeal right may be seized under execution (Code of Practice, art. 647). In this instance the bankrupt's rights in the policies are somewhat clouded by his designation of his wife as beneficiary, and in order to realize the cash surrender value he would be

compelled to change the designation. There are certain rights of a debtor his creditors cannot avail themselves of. Civil Code, arts. 1991 and 1992. But there is nothing in the law of Louisiana preventing the seizure of the cash surrender value of a life insurance policy: Where there is nothing specific in the law exempting them, a debtor cannot refuse to exercise his rights for the benefit of his creditors. Articles such as Civil Code, arts. 1991 and 1992, are considered exceptions to the general rule, to be strictly construed, and not extended by implication.

This doctrine is clearly enunciated by the Supreme Court of Louisiana. In Klotz vs. Macready, 44 La. Ann. 169, 10 South 706, a debtor was compelled to remove a cloud on his title to real estate for the benefit of a creditor who had no right of action in himself. In Belcher & Creswell vs. Johnson, 114 La. 640, 38 South. 481, where the debtor had the right to set aside a sale for lesion beyond moiety, he was compelled to exercise the right for the benefit of his creditors. In Fay & Egan Co. vs. Ouachita Excelsior Saw & Planing Mills, 50 La. Ann. 207, 23 South. 312, the seizure of an indefinite interest in a continuing contract was maintained, and the final disposition of the garnishment held in abeyance, to await the termination of the contract. There are other cases to the same effect. See authorities cited in the above cases.

In the light of these decisions and the general policy of the civil law, it is clear that the creditors of this bankrupt might well have looked to the policies herein surrendered for payment of their debts, and therefore they are not exempt under Act 189 of 1914.

The decision of the referee was right, and it will be affirmed.



SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FOURTH DEPARTMENT.

HOLLERAN

vs.

PRUDENTIAL INS. CO. OF AMERICA.*

1. INSURANCE—LIFE POLICIES—PASSAGE OF TITLE.

A writing executed by insured in the nature of an order on the company to pay the proceeds of his life policy to plaintiff is not sufficient alone to vest title to the policy in plaintiff; but where the policy is delivered, and it is the intention of the parties that title should be so vested, title passes.

(For other cases, see Insurance, Cent. Dig. § 479; Dec. Dig. § 209.)

* Decision rendered, April 19, 1916. 159 N. Y. Supp. 284.

2. INSURANCE—LIFE INSURANCE—SETTLEMENT.

Where the agent of a life insurance company informed plaintiff, who was the assignee of a policy, that he had come to pay the claim, and in that manner induced plaintiff to sign a receipt and release, but only delivered to plaintiff a small sum, which plaintiff had expended in payment of premiums, the release is not binding; plaintiff offering to return the money and demanding that the agent return him the document.

(For other cases, see *Insurance*, Cent. Dig. § 1499; Dec. Dig. § 603.)

3. INSURANCE—LIFE INSURANCE—WAIVER OF CONDITIONS.

Where a life insurance company accepted premiums from an assignee of a policy, and after the assignee had delivered the policy and premium receipt book attempted to secure a release from him of his claims, there was a waiver of a clause in the policy avoiding it on assignment.

(For other cases, see *Insurance*, Cent. Dig. § 1040; Dec. Dig. § 391.)

Appeal from Oneida County Court.

Action by James E. Holleran against the Prudential Insurance Company of America. From a judgment of the County Court, modifying a judgment of the City Court for plaintiff, defendant appeals. Affirmed.

Argued before Kruse, P. J., and Foote, Lambert, Merrell, and De Angelis, JJ.

Arthur J. Foley and Lewis, Foley & Foley, all of Utica, for Appellant. William F. Dowling and Lee & Dowling, all of Utica, for Respondent.

Foote, J.

On April 7, 1913, defendant company issued to Frank Von Ertfelda its policy of life insurance, whereby in consideration of a weekly payment of 20 cents it insured his life for the sum of \$244, payable at death. The insured died on December 26th of the same year. Plaintiff, claiming to be an assignee of the policy, brings this action to recover its amount. He has recovered on the theory that he is the owner of the policy. In his complaint, however, he alleged:—

"That shortly after the issuing of said policy, with the knowledge and consent of defendant, the policy was transferred by the insured to the plaintiff, as security for money owing by the insured to the plaintiff and in consideration of the plaintiff paying the weekly premiums thereon; that said policy was duly transferred and delivered into possession of the plaintiff, together with the weekly premium receipt book; that plaintiff is now the owner and holder of said policy and said book; that at all times herein mentioned the insured was indebted to the plaintiff, and plaintiff was creditor of said insured; that said debt was not discharged or paid by the insured."

Defendant, by its answer, admitted issuing the policy, put in issue the other allegations, and alleged as an affirmative defense that Von Ertfelda had falsely represented and warranted in his application that he had never used liquors to excess, whereas for a number of years he had been a confirmed user of liquor and

drank to excess, and for a third defense that plaintiff had, for a valuable consideration, released defendant from liability under the policy, and for a fourth defense that plaintiff is without legal capacity to sue and is not a proper party to this action.

The case was tried before the City Court of Utica. Plaintiff, as a witness, gave evidence of a transaction between himself and the insured in May, 1913, in which after some conversation the policy and premium receipt book were delivered to plaintiff, and plaintiff paid the overdue premiums and agreed to pay future premiums, and to pay the funeral expenses of insured. A paper was executed at this time by insured to plaintiff in the nature of an order on the insurance company to pay the proceeds of the policy to plaintiff.

[1] If plaintiff's case rested on this paper alone, it would not be sufficient to vest title to the policy in plaintiff; but, if the parties intended that plaintiff should become the owner of the policy, we think what was said and done at this time sufficient to effectuate such intent. The City Court has, in effect, decided that there was such an intent, and that plaintiff acquired title to the policy, and the County Court has found no error in this decision. We cannot say that it has not sufficient support in the evidence. At the time of the alleged assignment of the policy, insured was indebted to plaintiff to the amount of forty or fifty dollars. This was increased before the death of insured to \$126. Plaintiff incurred an expense of \$60 for insured's funeral expenses, and plaintiff paid in all \$7.20 premiums on the policy, thereby keeping it in force until the death of insured.

[2] After the death of insured, plaintiff delivered the policy and the premium receipt book to an agent of defendant and made claim for the amount of the policy. Some days later defendant's agent called at plaintiff's saloon and said he had some money for plaintiff, and requested plaintiff to sign his name to a paper, which plaintiff did without reading it, supposing, as he says, that he was to receive the full amount of the policy. After he had signed, however, the agent laid down upon the bar \$7.20, being the amount of premiums which plaintiff had paid. This plaintiff refused to accept, but the agent left the money there and took the paper which plaintiff had signed away with him. This paper, it seems, was a check for \$7.20 to plaintiff's order, and plaintiff's signature was written under the following indorsement on the back of the check:

"This check is in full payment of claim under policy or policies mentioned thereon, and the payee accepts it as such by indorsement below. No other receipt required."

The question principally litigated in the City Court was as to whether insured had been in the habit of using liquor to excess before he took out this policy. It appeared that plaintiff kept a saloon, and that the insured had been employed more or less about the saloon in cleaning it out. The City Court decided this issue in favor of plaintiff, and the County Court has affirmed it as a fair

question of fact, and we think rightly so. The learned county judge has written an opinion in which he holds, and we think correctly, that there was also a question of fact for the City Court as to the validity of the release which plaintiff signed upon the back of the check, in view of the circumstances under which plaintiff's signature to that paper was obtained. We think that question was rightly decided in favor of plaintiff, especially in view of the fact that plaintiff's testimony as to how that signature was obtained was in no way contradicted. No point is made that plaintiff was bound to tender back the \$7.20 before bringing this action.

[3] The policy by its terms is payable "to the executors or administrators of the insured unless payment be made under the provisions of the next succeeding paragraph." The next paragraph is headed "Facility of Payment," which gives the company the privilege of making payment "to any relative by blood or connection by marriage of the insured, or to any person appearing to said company to be equitably entitled to the same by reason of having incurred expense on behalf of the insured for his or her burial, or if the insured be more than fifteen years of age at the date of this policy, for any other purpose." The policy also contained a clause making it void "if the policy be assigned." The question is whether in view of this form of policy, which is new with this company, there can be a valid assignment of the policy.

We find but one authority in this state upon the question, which is the case of Heffernan vs. Prudential Ins. Co., 88 Misc. Rep. 93, 150 N. Y. Supp. 644. This was an Appellate Term case in the First Department, on appeal from the City Court of New York. The defendant in that case had not pleaded the assignment of the policy alleged in the complaint as a ground of forfeiture, but had moved to dismiss the complaint at the conclusion of the plaintiff's case upon that ground. This motion was reserved, and later denied, and judgment was given in favor of the plaintiff, upon two grounds: (1) That defendant was estopped from availing itself of the clause against assignment by acceptance of the premiums paid by plaintiff after defendant had become apprised of the assignment; and (2) that the avoiding of the contract for breach of condition against assignment was a matter of special defense, and could not be availed of on this pleading. On appeal it was held that this decision was erroneous, inasmuch as there was no proof that defendant had received payment of premiums from the plaintiff, or that any payments had been, in fact, made after defendant had knowledge of the assignment. As to the question of pleading it was held that, while the defendant could not offer affirmative proof of a breach of the condition subsequent without pleading it, that rule did not apply to a case where the facts relied upon as defense are pleaded and proved by the plaintiff as a part of plaintiff's case, and the conclusion reached by the Appellate Term was that:—

"By the very terms of the policy, it was void if assigned, and

the defendant's motion to dismiss the complaint at the close of the plaintiff's case should therefore have been granted."

The judgment of the City Court was reversed, and a new trial ordered.

In the cases cited in the opinion of the learned county judge to show that a life insurance policy is assignable, namely, Steinback vs. Diepenbrock, 158 N. Y. 24, 52 N. E. 662, 44 L. R. A. 417, 70 Am. St. Rep. 424, McGlynn vs. Curry, 82 App. Div. 431, 81 N. Y. Supp. 855, Griffin vs. Prudential Life Ins. Co., 43 App. Div. 499, 60 N. Y. Supp. 79, and McNevins vs. Prudential Ins. Co., 87 Misc. Rep. 608, 108 N. Y. Supp. 745, no question was presented, because there was no clause in the policies making them void in case of an assignment. In the Griffin Case there was a condition that the policy should not be assigned, unless in writing; but there was no condition that an assignment not in writing should render the policy void, and the court held that a failure to comply with the condition would not defeat the vesting of the legal title of the assignee and cited Marcus vs. St. Louis Mutual Life Ins. Co., 68 N. Y. 625, as authority for this proposition. The headnote to that case is:—

"A policy of life insurance contained a clause declaring that it could be assigned only on the written approval of the company; it did not declare that a violation of the provision would avoid the policy. In an action thereon, held (Miller J., dissenting), that a violation of this provision did not involve a forfeiture, and that an assignee could enforce the policy, although the insurer had not consented to the assignment."

We are aware of no principle or authority by which the clause forfeiting the policy in case of its assignment can be condemned as invalid; but we think we need not examine the question further, as we think the forfeiture, if there was one, was waived.

It is contended that the forfeiture clause was waived by the receipt of premiums from plaintiff after the assignment. But it does not appear that defendant had knowledge of the alleged assignment, or that the premiums subsequently paid were, in fact, paid by plaintiff in person or to defendant's knowledge. It may be, as plaintiff's counsel asserts, that the Mr. Leach, who was present at plaintiff's saloon at the time the alleged assignment was made, was an agent of defendant company, and that he, or some other agent of defendant, called upon plaintiff subsequently to collect the premiums; but these statements have not sufficient support in the evidence to be treated as established facts in the case.

Assuming that it was not necessary for defendant to plead the alleged forfeiture in its answer, inasmuch as the facts appeared sufficiently from the complaint, we think it can and should be held that defendant waived the forfeiture by recognizing a liability under the policy to plaintiff when it paid plaintiff \$7.20 after the death of the insured, accepted from plaintiff the policy and

premium book, and undertook to secure from plaintiff a receipt or release discharging defendant from further liability on the policy. Very little is required to waive a forfeiture under a life insurance contract after the capital fact of the death of the insured. Any act of the insurer after knowledge of the facts, which treats the contract as still in force, is usually held by the courts to constitute a waiver of forfeiture. The \$7.20 was paid by defendant to plaintiff under the policy, and not otherwise, and necessarily recognized that the policy was, to some extent, at least, in force as an existing contract. The payment must have been made to plaintiff as assignee, for the indorsement on the back of the check which plaintiff was required to sign states:—

"This check is in full payment of claim under policy or policies mentioned thereon, and the payee accepts it as such by endorsement below. No other receipt required."

The judgment should be affirmed, with costs. All concur.

**FLITTNER vs. EQUITABLE LIFE ASSUR. SOC. OF THE
UNITED STATES. (Civ. 1629.)***

(District Court of Appeal, First District, California.)

2. INSURANCE—CONTRACT—WHAT LAW GOVERNS.

Where insured received his policy in California upon his payment therein of the first year's premium in advance, the last act essential to consummation of the contract being done in California, the contract was made there.

(For other cases, see Insurance, Cent. Dig. § 174; Dec. Dig. § 125[2].)

**3. INSURANCE—CONTRACTS—WHAT LAW GOVERNS—PLACE
OF PERFORMANCE.**

Where a contract of insurance was made in California, but the policy provided that the payment of the benefits should be at the insurer's home office in New York, and that the premiums should also be payable there, and also provided that premiums might be paid to any agent or agency cashier of the insurer upon delivery of a receipt signed by an executive officer, but nowhere provided that agents authorized to receive premiums should be appointed or maintained in California, the contract was to be performed in New York, and was governed by the law of that state.

(For other cases, see Insurance, Cent. Dig. § 175; Dec. Dig. § 125[4].)

**4. INSURANCE—CONTRACT—WHAT LAW GOVERNS—PLACE
OF PERFORMANCE.**

The law of the place of performance of an insurance contract governs as to its construction and legal effect, and as to all matters connected with its performance.

(For other cases, see Insurance, Cent. Dig. § 293; Dec. Dig. § 147[3].)

* Decision rendered, March 27, 1916. Rehearing denied by Supreme Court, May 25, 1916. 157 Pac. Rep. 630.

5. INSURANCE—CONTRACTS—WHAT LAW GOVERNS—PLACE OF CONTRACT.

The law of the place where an insurance contract is made governs as to all matters bearing on the execution, interpretation, and validity of the contract, including the capacity of the parties to contract.

(For other cases, see Insurance, Cent. Dig. § 174; Dec. Dig. § 125[2].)

Appeal from Superior Court, City and County of San Francisco; Adolphus E. Graupner, Judge.

Action by Frank W. Flittner by Frank L. Trimble, his guardian ad litem, against the Equitable Life Assurance Society of the United States. Judgment for plaintiff, and defendant appeals. Affirmed.

Pillsbury, Madison & Sutro and Almon E. Roth, all of San Francisco, for Appellant.

Louis H. Brownstone, of San Francisco, for Respondent.

**ORDER OF SCOTTISH CLANS vs. REICH ET AL.***

(Supreme Court of Errors of Connecticut.)

1. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—RIGHT TO PROCEEDS.

No right or interest in a death benefit evidenced by the certificate of a beneficiary order, more than a revocable, contingent expectation not amounting to a property right, ever vested in the beneficiary named in the certificate who died before the insured.

(For other cases, see Insurance, Cent. Dig. § 1949; Dec. Dig. § 783.)

2. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—RIGHT TO PROCEEDS.

A provision in the laws of a fraternal beneficiary order that benefits will be paid to the beneficiary designated by the insured or to his legal representatives does not require payment to the legal representative of a beneficiary who predeceased insured.

(For other cases, see Insurance, Cent. Dig. §§ 1943, 1974; Dec. Dig. § 785.)

3. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—RIGHT TO PROCEEDS.

The widow of insured who has not been designated as the beneficiary of a fraternal benefit certificate is not entitled to receive the benefit at the death of the insured.

(For other cases, see Insurance, Cent. Dig. § 1939; Dec. Dig. § 773.)

4. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—RIGHT TO PROCEEDS.

The administratrix of a member of a fraternal beneficiary order has no claim to the benefit fund by virtue of a vested interest in insured at his death.

(For other cases, see Insurance, Cent. Dig. § 1973; Dec. Dig. § 795.)

* Decision rendered, June 2, 1916. 97 Atl. Rep. 863.

5. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—RIGHT TO PROCEEDS.

A provision in the laws of a fraternal order for the payment of benefits to the beneficiary or to the legal representative of a deceased member authorizes payment to the administratrix of the member, where the beneficiary named has predeceased him and no other beneficiary has been named.

(For other cases, see Insurance, Cent. Dig. §§ 1943, 1974; Dec. Dig. § 785.)

Appeal from Court of Common Pleas, Fairfield County; Howard B. Scott, Judge.

Action of interpleader by the Order of Scottish Clans against Herman Reich, administrator de bonis non of the estate of Margaret Campbell, and others, to determine the rights of the respective defendants to a death benefit of \$500 due from the plaintiff order. From a judgment for the defendant Reich, administrator, defendant Anna Campbell, individually and as administratrix of John Campbell, appeals. Reversed and remanded, with directions.

—————♦♦♦—————

OKLAHOMA TRIBE No. 26, IMPROVED ORDER OF RED MEN vs. MUSGROVE.*

(Superior Court of Delaware. Sussex.)

1. INSURANCE—FRATERNAL INSURANCE—RECOVERY OF BENEFITS.

In an action to recover a benefit payable by a fraternal order, the claimant must show that she was entitled under the laws of the order.

(For other cases, see Insurance, Cent. Dig. §§ 1999, 2000; Dec. Dig. § 817[1].)

2. INSURANCE—FRATERNAL INSURANCE—FUNERAL BENEFITS.

There is a presumption that a woman who had married a member of a fraternal order and had cohabited with him was living with him at the time of his death, within the by-laws of the order providing for payment of funeral benefits to her in case she was so living with him.

(For other cases, see Insurance, Cent. Dig. §§ 1999, 2000; Dec. Dig. § 817[1].)

3. INSURANCE—FRATERNAL INSURANCE—JURY QUESTION.

Where the wife of a member of a fraternal order who was entitled to funeral benefits provided she was living with him at the time of his death was temporarily absent at the time of death, the question whether she was living with the member within the by-laws is for the jury.

(For other cases, see Insurance, Cent. Dig. § 2009; Dec. Dig. § 825[1].)

4. INSURANCE—FRATERNAL INSURANCE—BY-LAWS.

The wife of a member of a fraternal order who claimed funeral benefits payable under the by-laws of the order is bound by such by-laws, and

* Decision rendered, April 11, 1916. 97 Atl. Rep. 867.

must show a compliance therewith and that she properly presented her claim in order to recover, being required to exhaust her remedies within the order before appealing to the courts.

(For other cases, see Insurance, Cent. Dig. §§ 1999, 2000; Dec. Dig. § 817[1].)

Action by Eugenia Musgrove against the Oklahoma Tribe No. 26, Improved Order of Red Men, begun in justice court, and appealed to the superior court. Charge to jury.

Appeal from a judgment of a justice of the peace, No. 19, June term, 1914.

Argued before Rice and Heisel, JJ.

Andrew J. Lynch and John M. Richardson, both of Georgetown, for Appellant.

Frank M. Jones, of Georgetown, for Respondent.



RIDGEWAY *vs.* MODERN WOODMEN OF AMERICA.
(No. 1994.)*

(Supreme Court of Kansas.)

1. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—FORFEITURE—WAIVER.

Where the by-laws of a fraternal beneficiary society provide that the engaging by a member in a specified dangerous occupation shall exempt it from liability on account of his death directly traceable thereto, the acceptance of dues from a member after he has engaged in such occupation, with knowledge of the fact, does not constitute a waiver of the exemption referred to.

(For other cases, see Insurance, Cent. Dig. §§ 1909-1913, 1915, 1916; Dec. Dig. § 755[3].)

2. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—FORFEITURE—WAIVER.

No waiver results in that situation from the fact that the society, after learning that a member has lost his life through engaging in the prohibited occupation, at the request of the beneficiary furnishes blanks upon which to make proofs of death, without giving notice of an intention to resist payment, otherwise than by a general statement that the supplying or use of the blanks should waive no right to deny liability.

(For other cases, see Insurance, Cent. Dig. § 1907; Dec. Dig. § 755[1].)

Appeal from District Court, Saline County.

Action by Belle Ridgeway against the Modern Woodmen of America. Judgment for plaintiff, and defendant appeals. Reversed and remanded, with directions to render judgment for defendant.

* Decision rendered, June 10, 1916. 157 Pac. Rep. 1191. Syllabus by the Court.

L. W. Hamner, of Salina, Truman Plantz, of Warsaw, Ill., and Geo. G. Perrin, of Rock Island, Ill., for Appellant.
Z. C. Millikin, of Salina, for Appellee.



METROPOLITAN LIFE INS. CO. *vs.* NELSON.*

(Court of Appeals of Kentucky.)

1. INSURANCE—LIFE INSURANCE—INSURABLE INTEREST.

One who has no insurable interest in the life of another cannot be the beneficiary in a policy issued upon his life and cannot collect the insurance upon the insured's death.

(For other cases, see Insurance, Cent. Dig. §§ 136-138; Dec. Dig. § 114.)

2. INSURANCE—LIFE INSURANCE—INSURABLE INTEREST—ASSIGNMENT.

The rule of insurance law relative to insurable interest applies with equal force after a life policy is issued, and the beneficiary is changed by assignment or otherwise as it does to the naming of the beneficiary at the time of procuring the insurance.

(For other cases, see Insurance, Cent. Dig. §§ 166, 167; Dec. Dig. § 122.)

3. INSURANCE—LIFE INSURANCE—INSURABLE INTEREST—CREDITOR.

A creditor, to the extent of his debt, has an insurable interest in the life of his debtor.

(For other cases, see Insurance, Cent. Dig. § 162; Dec. Dig. § 116[5].)

4. INSURANCE—LIFE INSURANCE—INDUSTRIAL INSURANCE—INTEREST.

Payment by the insurance company which issued a policy of "industrial insurance," the purpose of which is to provide a reasonable fund with which insured may alleviate his last sickness and secure decent burial, to insured's aunt, his beneficiary, who cared for him in his sickness and buried him, was permissible under the usual "facility of payment" clause in such a policy, providing that payment might be made to the beneficiary or any person equitably entitled, etc., though the aunt had no insurable interest in insured's life.

(For other cases, see Insurance, Cent. Dig. § 1485; Dec. Dig. § 583[2].)

Appeal from Circuit Court, Jefferson County, Common Pleas Branch, First Division.

Suit by Elnora Nelson, etc., against the Metropolitan Life Insurance Company. There was judgment for plaintiff and defendant files a transcript of the record, and enters motion that it be granted an appeal from judgment. Motion for appeal sustained, appeal granted, and judgment reversed for proceedings consistent with the opinion.

Clarence Smith and Keith L. Bullitt, both of Louisville, for Appellant.
L. Frank Withers and L. A. Hickman, both of Louisville, for Appellee.

* Decision rendered, June 8, 1916. 186 S. W. Rep. 520.

**MUTUAL LIFE INS. CO. OF NEW YORK ET AL. VS. SPOHN
ET AL.***

(Court of Appeals of Kentucky.)

1. INSURANCE—LIFE INSURANCE—RIGHT TO PROCEEDS.

Under Ky. St. § 2064, providing that when a devise is made to several as a class or as tenants in common, or as joint tenants, and one or more of the devisees shall die before the testator, and another or other shall survive the testator, the share or shares of such as die shall go to descendants, or, if none, to surviving devisees, unless a different disposition is made by the devisor, a policy of insurance being regarded as testamentary in character, where the insured takes out a policy on his own life for the benefit of his wife, and upon her death for the benefit of his children, and after the death of the wife one of the children dies without issue before the insured, his part goes to the surviving beneficiaries.

(For other cases, see Insurance, Cent. Dig. §§ 1472-1474; Dec. Dig. § 589.)

2. INSURANCE—LIFE INSURANCE—RIGHT TO PROCEEDS.

Under Ky. St. § 654, authorizing a woman without the consent of her husband to insure his life for the benefit of herself and children, where a policy of insurance was for the benefit of the wife of the deceased and the contract showed on its face that the first annual premium was paid by the wife, and that she was to continue to pay the premium, and the policy contained a direct promise to pay the policy to the wife or, if she were not living, to her children or their guardian, the policy was a contract with the wife of the insured, any payments by the insured being made as her agent, and hence the policy is not in the nature of a testamentary disposition, and a child at the death of the mother took a vested interest which he could transmit by will to his widow.

(For other cases, see Insurance, Cent. Dig. § 1470; Dec. Dig. § 586.)

Appeal from Circuit Court, Harrison County.

Suit by Frank Spohn and others against the Mutual Life Insurance Company of New York and another. From the judgment against plaintiff Sudie Spohn, she appeals. Reversed and remanded.

Wade H. Lail, of Cynthiana, and Grubbs & Grubbs, of Louisville, for Appellant.

M. C. Swinford, of Cynthiana, for Appellees.

* Decision rendered, June 13, 1916. 186 S. W. Rep. 633.

**NEWPORT BENEV. BURIAL ASS'N vs. CLAY, INS. COM'R.
KENTON & CAMPBELL BENEV. BURIAL ASS'N vs.**

SAME.*

(Court of Appeals of Kentucky.)

1. INSURANCE—BURIAL ASSOCIATIONS—STATUTES GOVERNING.

While Ky. St. § 664, regulating and defining life insurance companies on the assessment or co-operative plan, is broad enough to include assessment burial associations, they are not required to comply with such chapter as to organizing, the Legislature by section 199a having provided special laws governing such associations different from the general insurance laws.

(For other cases, see Insurance, Cent. Dig. §§ 49, 64, 65; Dec. Dig. § 52.)

2. INSURANCE—BURIAL ASSOCIATIONS—STATUTES GOVERNING.

Where the Legislature amended statutes governing assessment and co-operative life insurance companies, and on the same day enacted other sections specifically applying to burial associations, it was conclusive of the intent to separate life insurance companies from burial associations, and place the latter in a class by themselves.

(For other cases, see Insurance, Cent. Dig. §§ 49, 64, 65; Dec. Dig. § 52.)

4. INSURANCE—CONSTRUCTION—REPUGNANCY.

Ky. St. §§ 660-681a, relating to assessment and co-operative life insurance companies, and section 199a, relating to burial associations, are not repugnant to each other, although they deal to some extent with the same subject-matter, and, being capable of enforcement together consistently, both must be upheld and enforced.

(For other cases, see Insurance, Cent. Dig. § 4; Dec. Dig. § 4.)

7. INSURANCE—BURIAL ASSOCIATIONS—STATUTES GOVERNING.

Ky. St. § 199a, subd. 1, provides the procedure for organizing burial associations. Subdivision 2 requires such associations to make a certain deposit with the treasurer, and provides the procedure on dissolution of such associations, but provides that "the provisions of this act shall not apply to corporation, association or company that has no capital stock, pays no salaries or commissions to officers and whose sole resources except necessary expenses are devoted to paying funeral expenses of members." Held, that associations enumerated in the proviso are excepted only from provisions of subdivision 2, and are not from remainder of section 199a, so that they cannot be required to comply with the general insurance law, but are governed only by section 199a.

(For other cases, see Insurance, Cent. Dig. § 74; Dec. Dig. § 57[1].)

Appeal from Circuit Court, Franklin County.

Two suits for injunction, by the Newport Benevolent Burial Association, and by the Kenton & Campbell Benevolent Burial Association, against M. C. Clay, Insurance Commissioner. From orders sustaining demurrers to the petition and judgments dismissing both petitions, both

* Decision rendered, June 7, 1916. 186 S. W. Rep. 658.

plaintiffs appeal. The cases were heard together. Judgments reversed and remanded.

Wm. A. Byrne, of Covington, Barbour & Bassman, of Newport, and Byrne & Read, of Covington, for Appellants.

M. M. Logan, Atty. Gen., C. H. Morris, Asst. Atty. Gen., and G. E. Zimmerman, of Louisville, for Appellee.



O'CONNOR'S ADM'R *vs.* EQUITABLE LIFE ASSUR.
SOCIETY OF UNITED STATES.*

(Court of Appeals of Kentucky.)

1. INSURANCE—INSURABLE INTEREST—ASSIGNMENT OF POLICY.

The validity of a life insurance policy, as against objection that an assignment thereof was an evasion of the prohibition against the issuance of policies to beneficiaries having no insurable interest, must be determined by the contract between insured and beneficiary prior to or at time of the issuance of the policy, and any subsequent agreement between the insured and the beneficiary cannot affect the rights of the insurer.

(For other cases, see Insurance, Cent. Dig. §§ 166, 167; Dec. Dig § 122.)

2. INSURANCE—ACTION ON POLICY—EVIDENCE—SUFFICIENCY.

In an action on a life insurance policy, evidence *held* sufficient to support a directed verdict for defendant on the ground that an assignment of the policy was an attempted evasion of the law prohibiting the issuance of policies to persons having no insurable interest in the life of the insured.

(For other cases, see Insurance, Cent. Dig. § 1708; Dec. Dig. § 665[1].)

Appeal from Circuit Court, Jefferson County, Common Pleas Branch, Second Division.

Action by John O'Connor's administrator against the Equitable Life Assurance Society of the United States. Judgment for defendant, and plaintiff appeals. Affirmed.

David R. Castleman and Pryor & Castleman, all of Louisville, for Appellant.

Humphrey, Middleton & Humphrey, of Louisville, for Appellee.

* Decision rendered, June 9, 1916. 186 S. W. Rep. 502.

**BROMBERG vs. NORTH AMERICAN LIFE INS. CO.
(No. 210.)***

(Supreme Court of Michigan.)

3. INSURANCE—ACTIONS—LIFE INSURANCE—QUESTIONS FOR JURY.

Evidence that deceased died from a gunshot wound in the head, that he was not feeling well, that a revolver was found in his hand, with no indication of a struggle preceding the shooting, and that no one had access to his room except his family, together with public records showing suicide, raised an issue of fact for the jury.

(For other cases, see Insurance, Cent. Dig. § 1763; Dec. Dig. § 668[12].)

Error to Circuit Court, Wayne County; Howard Wiest, Judge. Action by Aaron Bromberg against the North American Life Insurance Company. Judgment for defendant, and plaintiff brings error. Affirmed.

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, Person, and Brooke, JJ.

George W. Bates, of Detroit, for Appellant.
Stellwagen & MacKay, of Detroit, for Appellee.

* Decision rendered, June 2, 1916. 158 N. W. Rep. 141.

**NEW ERA ASS'N vs. KUYAT ET AL. (No. 177.)***

(Supreme Court of Michigan)

1. INSURANCE—BENEFIT ASSOCIATION—CHANGE OF BENEFICIARY.

Where the constitution of an association permitted change of beneficiary upon the signing of a waiver of the original certificate, the insured had the right, without consent of the beneficiary or notice to the beneficiary by the association, to change the beneficiary in his policy, as the first beneficiary has no vested right in the policy.

(For other cases, see Insurance, Cent. Dig. § 1949; Dec. Dig. § 783.)

2. INSURANCE—BENEFIT INSURANCE—CHANGE OF BENEFICIARY—ESTOPPEL.

Where it did not appear that a post card sent by an agent of the plaintiff benefit insurance association, informing the wife of the deceased that assessments paid by her were on the original certificate in which she was named as full beneficiary, in any way influenced or injured her, the association was not estopped to assert that the original certificate had been waived by the deceased, a new policy issued, and a partial change of beneficiary.

(For other cases, see Insurance, Cent. Dig. § 1948; Dec. Dig. § 782.)

* Decision rendered, June 1, 1916. 158 N. W. Rep. 119.

3. INSURANCE—BENEFIT ASSOCIATIONS—CHANGE OF BENEFICIARY—MODE—RATIFICATION.

Where deceased personally signed his name at the bottom of a new certificate, he agreed to its terms and ratified a change of beneficiary.
(For other cases, see Insurance, Cent. Dig. § 1951; Dec. Dig. § 784[4].)

Appeal from Circuit Court, Wayne County, in Chancery.

Interpleader by the New Era Association against Emma R. Kuyat and another. Decree for defendant Sophia Kenzie, and said Kuyat appeals. Affirmed.

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, Brooke, and Person, JJ.

Moore & Moore, of Detroit, for Appellant.

Kleinhaus, Knappen & Uhl, of Grand Rapids (Lucking, Helfman, Lucking & Hanlon, of Detroit, of counsel), for Appellee New Era Ass'n. James F. Hill, of Detroit, for Appellee Kenzie.



ALEXANDER vs. SOVEREIGN CAMP OF WOODMEN OF THE WORLD ET AL. (No. 11944.)*

(Kansas City Court of Appeals. Missouri.)

4. INSURANCE—MUTUAL BENEFIT—RIGHTS OF BENEFICIARY.

The beneficiary of a mutual benefit life insurance policy, which entitles the insured to change the beneficiary at will, has no vested interest in the policy.

(For other cases, see Insurance, Cent. Dig. § 1949; Dec. Dig. § 783.)

Error to Circuit Court, Buchanan County; Chas. D. Mayer, Judge.

"To be officially published."

Suit by Charles S. Alexander against the Sovereign Camp of Woodmen of the World, in which Mary E. Alexander was interpledged on defendant's prayer. From the judgment rendered, plaintiff brings error. Affirmed.

Ferrell & Zwick, of St. Joseph, for Plaintiff in Error.

W. B. Norris and Wm. M. Morton, both of St. Joseph, for Defendant in Error.

* Decision rendered, May 1, 1916. 186 S. W. Rep. 2.

MILLER vs. MISSOURI STATE LIFE INS. CO.

(No. 11555.)*

(Kansas City Court of Appeals. Missouri.)

1. INSURANCE—LIFE INSURANCE—OLD-LINE OR ASSESSMENT.

Life insurance is old-line, and not assessment, the policy providing for payment of fixed quarterly premiums, and containing no provision for payment of death benefits from proceeds of assessments, in case of excessive death rate, and referring to no by-law providing therefor, and such a by-law not being brought into the policy by its reference to the application, which contains the agreement of insured that if he omit to make any of the payments at the place and time required by the policy and insurer's by-laws the policy shall be void; the by-laws referred to in the application being only those relating to fixed quarterly payments.

(For other cases, see Insurance, Cent. Dig. §§ 172, 178; Dec. Dig. § 124.)

Appeal from Circuit Court, Johnson County; Samuel Davis, Special Judge.

"To be officially published."

Action by Thomas H. Miller against the Missouri State Life Insurance Company. Judgment for plaintiff, and defendant appeals. Reversed and remanded, with directions for judgment.

Nick M. Bradley and M. D. Aber, both of Warrensburg, for Appellant.

Jones, Hocker, Sullivan & Angert, of St. Louis, J. W. Suddath & Son, of Warrensburg, and James C. Jones, Jr., of St. Louis, for Respondent.

* Decision rendered, May 24, 1915. On rehearing, May 22, 1916. 186 S. W. Rep. 762.

**BANKERS' LIFE CO. vs. CHORN, INS. SUPERINTENDENT.**

(No. 18823.)*

(Supreme Court of Missouri. In Banc.)

1. INSURANCE—PRIVILEGE TAX—STATUTORY CONSTRUCTION.

R. S. 1909, § 7099, imposing a premium duty or tax on foreign insurance companies, is a part of the general insurance laws, and therefore inapplicable to assessment insurance companies under R. S. 1909, § 6959, excepting such companies from the requirements of the general insurance laws.

(For other cases, see Insurance, Cent. Dig. § 6; Dec. Dig. § 7.)

* Decision rendered, May 15, 1916. Rehearing denied, June 2, 1916. 186 S. W. Rep. 681.

5. INSURANCE—PRIVILEGE TAX—STATUTORY CONSTRUCTION—"PREMIUM."

R. S. 1909, § 7099, imposing a duty on the "premiums" received by foreign insurance companies does not apply to "assessments," since there is an essential difference between the insurance companies receiving such payments.

(For other cases, see Insurance, Cent. Dig. § 6; Dec. Dig. § 7.)

(For other definitions, see Words and Phrases, First and Second Series, Premium.)

Appeal from Circuit Court, Cole County; J. G. Slate, Judge.

Action by the Bankers' Life Company against Walter K. Chorn, as Superintendent of Insurance. Judgment for defendant, and plaintiff appeals. Reversed and remanded, with directions.

Lehmann & Lehmann, of St. Louis, and I. M. Earle, of Des Moines, Iowa, for Appellant.

Earl F. Nelson, of Milan, for Respondent.

PASSACONAWAY COUNCIL *vs.* DOW.*

(Supreme Court of New Hampshire. Rockingham.)

INSURANCE—MUTUAL BENEFIT INSURANCE—BENEFICIARIES—WHO MAY BE BENEFICIARIES.

Where by-laws of a beneficial association provided that funeral benefits were payable only to certain legal dependents of a deceased member upon death of a member payment was properly made to his widow, although before death he had notified the association to make his insurance payable to his aunt, a blood relative not dependent on him.

(For other cases, see Insurance, Cent. Dig. § 1944; Dec. Dig. § 777.)

Transferred from Superior Court, Rockingham County; Young, Judge.

Bill of interpleader by Passaconaway Council against Mrs. Dow and another. To an order in favor of defendant Mrs. Knowles, the other named defendant, excepted. Transferred. Exceptions overruled.

Bill of interpleader to determine the right to a funeral benefit payable upon a certificate of membership issued to Frank L. Knowles. The by-laws provided that funeral benefits are payable only to legal dependents of a deceased member, and that such dependent must be the wife, children, parents, sisters, or brothers, grandparents, or grandchildren or other blood relative or other person who is dependent upon the member. Before his death Knowles notified the Council to make his insurance payable to the defendant, Mrs. Dow, his aunt, who was a blood relative, but not dependent upon him, and at his death he had not recalled this notice. The court ordered payment to the defendant widow, Mrs. Knowles, and the defendant Dow excepted. Transferred by Young, J.

Ernest L. Guptill, of Portsmouth, for Dow.
Eastman, Scammon & Gardner, of Exeter, for Knowles.

* Decision rendered, Jan. 4, 1916. 97 Atl. Rep. 878.

ADICKES vs. DREWRY. (No. 537.)*

(Supreme Court of North Carolina.)

2. INSURANCE—AGENCY CONTRACTS—CANCELLATION.

Where an agent rendered services under a written contract with the general agent of an insurance company which was approved by the company, and where there was a supplemental agreement, and later a new contract between the parties increasing the agent's drawing allowance and allowing an additional 1 per cent on the nine renewal commissions allowed him, a subsequent new contract, whereby the drawing amount was again increased and the additional 1 per cent and the first contract was expressly canceled, annulled all previous agreements, and was an accord and satisfaction of them.

(For other cases, see Insurance, Cent. Dig. §§ 111, 114; Dec. Dig. § 84[1].)

Appeal from Superior Court, Buncombe County; Webb, J.

Action by H. F. Adickes against John C. Drewry. Judgment for defendant on his motion for nonsuit and action dismissed, and plaintiff excepts and appeals. Affirmed.

Bourne, Parker & Morrison, T. F. Davidson, and R. B. Loughran, all of Asheville, for Appellant.

A. B. Andrews, Jr., of Raleigh, and Martin, Rollins & Wright, of Asheville, for Appellee.

* Decision rendered, May 31, 1916. 89 S. E. Rep. 23.

**MODERN ORDER OF PRÆTORIANS vs. KENNEDY**

(No. 7500.)*

(Supreme Court of Oklahoma.)

INSURANCE—MUTUAL BENEFIT INSURANCE—WARRANTIES.
Where a member of a benefit society whose death benefit certificate issued by such society had lapsed for failure to promptly pay an assessment applied in writing for the reinstatement thereof, and neither the constitution nor by-laws of the order required such form of application, held, that the society was without power to impose the making of a formal written application as a condition precedent to the reinstatement of such member, and that in an action by the beneficiary named therein to recover on such certificate, the statements contained in such application were not binding upon such beneficiary as warranties or otherwise.

(For other cases, see Insurance, Cent. Dig. § 1921; Dec. Dig. § 761.)

* Decision rendered, May 23, 1916. 157 Pac. Rep. 926. Syllabus by the Court.

Commissioners' opinion, Division No. 3. Error from District Court, Atoka County; Robt. M Rainey, Judge

Action by James J. Kennedy against the Modern Order of Praetorians, a corporation. Judgment for plaintiff, and defendant brings error. Affirmed.

J. G. Ralls, of Atoka, for Plaintiff in Error.
W. S. Farmer, of Atoka, for Defendant in Error.

COMMONWEALTH *vs.* PENN MUT. LIFE INS. CO.*

(Supreme Court of Pennsylvania.)

TAXATION—PROPERTY SUBJECT—INSURANCE PREMIUMS.

Under Act June 1, 1889 (P. L. 420) § 24, imposing on insurance companies a tax on premiums from business transacted within the commonwealth in computing the amount of gross premiums received by life insurance company, dividends payable to the insured and actually credited upon the premiums payable by them respectively are properly deducted.

(For other cases, see Taxation, Cent. Dig. §§ 648-651; Dec. Dig. § 387.)

Appeal from Court of Common Pleas, Dauphin County.

Action by the Commonwealth against the Penn Mutual Life Insurance Company. From a judgment for defendant on appeal from a tax settlement, plaintiff appeals. Affirmed.

Wm. M. Hargest, Deputy Atty. Gen., and Francis Shunk Brown, Atty. Gen. for the Commonwealth.

George Wharton Pepper and B. F. Pepper, both of Philadelphia, for Appellee.

* Decision rendered, March 6, 1916. 97 Atl. Rep. 677.



WICHITA SOUTHERN LIFE INS. CO. *vs.* ROBERTS.

(No. 554.)*

(Court of Civil Appeals of Texas. El Paso.)

1. INSURANCE—ACTIONS—EVIDENCE—WAIVER.

In an action on life insurance policy, which was extended by notes for the premium until a short time before the death of insured, evidence held not to show an agreement to extend the payment of premium note and the policy insurance during the month in which insured died.

(For other cases, see Insurance, Cent. Dig. §§ 1711-1716; Dec. Dig. § 665[3].)

* Decision rendered, May 4, 1916. Rehearing denied May 25, 1916. 186 S. W. Rep. 411.

2. INSURANCE—WAIVER—ACCEPTANCE OF NOTE FOR PREMIUM.

A letter of insurer to insured that a note would be accepted "as settlement of premium" did not alter the legal effect of provisions in note and policy that on nonpayment of note at maturity, the policy insurance would cease.

(For other cases, see Insurance, Cent. Dig. § 1019; Dec. Dig. § 384.)

3. INSURANCE—WRITTEN WAIVER.

Formal notice that if a policy were in force on a day (its annual premium date), a certain premium amount would be payable, having written on the back that it was not a waiver of any default, sent out by a subordinate employee having no authority to extend time payment of notes for premiums, did not waive right to forfeit the policy on non-payment of note given for premium.

(For other cases, see Insurance, Cent. Dig. § 1019; Dec. Dig. § 384.)

4. INSURANCE—RIGHTS OF BENEFICIARY—INCORPORATING NEW CONDITIONS.

After a life policy has lapsed by its terms for nonpayment of premium, the act of insured in executing a note, containing a new forfeiture condition in order to obtain a reinstatement of the policy, is binding on the beneficiary.

(For other cases, see Insurance, Cent. Dig. § 933; Dec. Dig. § 365[2].)

Appeal from District Court, Haskell County; Jno. B. Thomas, Judge. Action by Mary E. Roberts against the Wichita Southern Life Insurance Company. From a judgment for plaintiff, defendant appeals. Reversed, and judgment rendered for defendant.

Carrigan, Montgomery & Britain, of Wichita Falls, H. G. McConnell, of Haskell, and J. F. Woodson, of El Paso, for Appellant.

W. H. Murchison, of Haskell, and Theo. Mack, of Ft. Worth, for Appellee.



AMERICAN NAT. INS. CO. vs. THOMPSON ET AL.

(No. 7143.)*

(Court of Civil Appeals of Texas. Galveston.)

1. INSURANCE—CONSTRUCTION OF POLICY—COMMENCEMENT OF RISK—"FIRST POLICY YEAR."

A life policy was issued August 11, 1913, the first annual premium to be paid November 29, 1913, and annually thereafter, with a rider attached for the short term from July 29, 1913, to November 29, 1913. Premiums on both policies were paid. The main policy provided that it should be void if insured committed suicide within a year. Held, that the year began to run from the date of the short-term policy, and suicide November 6, 1914, did not avoid the policy.

(For other cases, see Insurance, Cent. Dig. § 1157; Dec. Dig. § 445[3].)

* Decision rendered, April 14, 1916. Rehearing denied, May 4, 1916. 186 S. W. Rep. 254.

Appeal from District Court, Houston County; John S. Prince, Judge.

Action by T. W. Thompson and another against the American National Insurance Company. From a judgment for plaintiffs, defendant appeals. Affirmed.

Nunn & Nunn, of Crockett, and Williams & Neethe, of Galveston, for Appellant.

Aldrich & Crook, of Crockett, for Appellees.



BEDNAREK vs. BROTHERHOOD OF AMERICAN YEO-

MEN. (No. 2841.)*

(Supreme Court of Utah.)

1. INSURANCE—FRATERNAL INSURANCE—CONDITION TO ACTION—SUBMISSION TO ARBITRATION.

Where a fraternal insurance association denied it was under any obligation to pay a death benefit, and the beneficiary, before suing, requested that the matter be submitted to a board of arbitration, as provided in the certificate of membership, to which the association failed and neglected to consent, the beneficiary could bring her action for the death benefit, despite the provision of the certificate that no action could be maintained under it, unless a board of arbitration should fail to settle the claim.¹

(For other cases, see Insurance, Cent. Dig. § 1987; Dec. Dig. § 805[1].)

2. INSURANCE—FRATERNAL INSURANCE—INFORMATION OF MEDICAL EXAMINER—SUFFICIENCY OF EVIDENCE.

In an action against a fraternal insurance order for a death benefit, evidence held sufficient to support finding that the medical examiner, when he made the examination of the applicant for insurance, was informed that the latter had undergone an operation for appendicitis.

(For other cases, see Insurance, Dec. Dig. § 819[3].)

4. INSURANCE—FRATERNAL INSURANCE—FALSE STATEMENT REGARDING HEALTH.

An applicant for life insurance must answer truthfully every question put to him by the medical examiner regarding the present and last state of his health; and if any statement made by him is untrue in any material matter, its falsity voids the contract of insurance, though made without fraudulent intent.

(For other cases, see Insurance, Cent. Dig. § 1863; Dec. Dig. § 723[5].)

5. INSURANCE—LIFE INSURANCE—WRITTEN WARRANTIES—WAIVER.

Where an applicant for insurance makes truthful statements to the medical examiner respecting his health, and his policy is issued to him, the insurer will be deemed to have waived the written warranties in the

* Decision rendered, April 29, 1916. 157 Pac. Rep. 884.

¹ Moran vs. Knights of Columbus, 151 Pac. 863; Daniher vs. Grand Lodge, A. O. U. W., 110, 37 Pac. 245.

application and policy, in so far as they are not in accord with the facts disclosed to examiner.
(For other cases, see Insurance, Cent. Dig. § 1866; Dec. Dig. § 724[2].)

6. INSURANCE—LIFE INSURANCE—FALSE WARRANTIES AS TO HEALTH.

Where the false statements of an applicant for life insurance, made warranties by the policy, relate to mere temporary ailments or a slight indisposition, that in no way tended to impair or prejudicially influence the health or longevity of the insured, such as tonsilitis and biliousness, such statements will not render the policy void, since such warranties are to be construed with reference to the general object of the inquiry, which is to ascertain whether the applicant is a good risk.

(For other cases, see Insurance, Cent. Dig. § 1863; Dec. Dig. § 723[5].)

Appeal from District Court, Salt Lake County; F. C. Loofbourou, Judge.

Action by Lillian Bednarek against the Brotherhood of American Yeomen, a corporation. From a judgment for plaintiff, defendant appeals. Judgment affirmed.

Scott & Hackett, of Salt Lake City, for Appellant.
C. S. Varian and M. E. Wilson, both of Salt Lake City, for Respondent.



ALGOE *vs.* PACIFIC MUT. LIFE INS. CO. OF CALIFORNIA.*

(Supreme Court of Washington.)

1. INSURANCE—FORFEITURE AND LOAN PROVISIONS—CONSTRUCTION.

Where the application provided that a policy should lapse for nonpayment of any premium and that all previous payments should be forfeited; that the insured might borrow a percentage of its cash value, and that his indebtedness should first be deducted in any settlement of the policy; that on lapse after it had been in force for three years, its full value after payment of any indebtedness would be extended, without request, as nonparticipating term insurance; and that if insured died within three years after such lapse, all unpaid premiums should be deducted from the amount insured; where the insured obtained a loan of part of the cash value and died after default in payment of a premium and before repayment of the loan, leaving an excess of policy value over the loan sufficient, if applied after the lapse, to purchase nonparticipating term insurance for the full amount of the policy—the fact of the loan did not forfeit the right to extended insurance for the full amount of the policy, and it was automatically extended for the full amount.

(For other cases, see Insurance, Cent. Dig. § 935; Dec. Dig. § 367[1].)

* Decision rendered, June 1, 1916. 157 Pac. Rep. 993.

2. INSURANCE—LOAN AND FORFEITURE PROVISIONS—CONSTRUCTION.

Under the loan contract in such case the provision that upon any default in premium or interest the insurer might terminate the policy and collect the loan by deducting and retaining it from the reserve on the policy and apply the excess as a single premium to the purchase of fully paid-up insurance was intended only to furnish the insurer a means of foreclosing the lien on the policy by canceling it prior to a loss thereon incurred by the death of the insured, and not as a forfeiture of rights or a cancellation of liabilities which had become vested by the insured's death, so that the insurer had no right to forfeit the extended insurance after the death of the insured.

(For other cases, see Insurance, Cent. Dig. § 935; Dec. Dig. § 367[1].)

3. INSURANCE—CONTRACTS—CONSTRUCTION AGAINST INSURER.

As policies are prepared by experts who know and can anticipate the bearing and conflicting complications of every contingency, and as the words are those of the insurer's selection, the courts, in fairness to parties purchasing insurance, must construe every ambiguity in their favor.

(For other cases, see Insurance, Cent. Dig. § 295; Dec. Dig. § 146[3].)

Department 1. Appeal from Superior Court, Spokane County; Jos. Sessions, Judge.

Action by Lottie B. Algoe against the Pacific Life Insurance Company of California. Judgment for plaintiff, and she appeals. Reversed, and cause remanded, with direction.

Zent, Powell & Redfield, of Spokane, for Appellant.
Winfield R. Smith, of Seattle, for Respondent.

**NORTHWESTERN MUT. LIFE INS. CO. vs. STATE.***

(Supreme Court of Wisconsin.)

TAXATION—SECURITIES AND CREDITS—EXEMPTION—UNCONDITIONAL DEBTS.

The liability of a life insurance company to policyholders, the present value of its outstanding policies, valued as required by law, is not an "unconditional debt," within the exemption of the old law for taxation of securities and credits.

(For other cases, see Taxation, Cent. Dig. § 162; Dec. Dig. § 76.)

On demurrer to amended complaint. Sustained, and action dismissed. For former opinion, see 155 N. W. 609.

Olin, Butler, Stebbins & Stroud, of Madison, for Plaintiff.
W. C. Owen, Atty. Gen., and Walter Drew, Deputy Atty. Gen., for the State.

* Decision rendered, June 13, 1916. 158 N. W. Rep. 328.

FIRE, TORNADO, ETC.**SUPREME COURT OF KANSAS.****GRAIN DEALERS' MUT. FIRE INS. CO.***vs.***MISSOURI, K. & T. RY. CO. ET AL. (No. 20229.)*****1. PARTIES—SUBROGATION—INSURANCE—ACTION AGAINST WRONGDOER.**

The rule that where the loss on an insurance policy exceeds the amount of the insurance, an action against the wrongdoer for the recovery of the part paid by the insurer must be brought in the name of the assured is a general rule to which there are exceptions. It will not be applied where the assured, after settling with the wrongdoer out of court, arbitrarily refuses to bring the action.

(For other cases, see Parties, Cent. Dig. §§ 15, 16; Dig. § 16.)

2. PARTIES—INSURANCE—SUBROGATION—ACTION AGAINST WRONGDOER.

In the situation stated in the preceding paragraph the insurer may, under section 5629, Gen. St. 1909 (Code Civ. Proc. § 36), bring an action in its own name, joining the assured as a defendant, and alleging his refusal to bring the action, and that he is joined as defendant in order to protect the other defendant's right to have the entire matter litigated in one action.

(For other cases, see Parties, Cent. Dig. §§ 15, 16; Dec. Dig. § 16.)

Appeal from District Court, Neosho County.

Action by the Grain Dealers' Mutual Fire Insurance Company against the Missouri, Kansas & Texas Railway Company and another. A demurrer to the petition was sustained, and plaintiff appeals. Remanded.

A. B. Harris, of Kansas City, Stone & McDermott, of Topeka, and E. W. Grant, of Erie, for Appellant.

W. W. Brown and James W. Reid, both of Parsons, and John J. Jones, of Chanute, for Appellees.

PORTER, J.

The plaintiff insurance company issued a policy on an elevator owned by L. G. Murray, one of the defendants. The property was destroyed by fire set out by the defendant railway company in the operation of its road, and the plaintiff paid to Murray the sum of \$2,910 on account of his loss. His actual loss exceeded the insurance by \$1,439.40. The policy contained the usual clause, giving the company the right of subrogation where the loss has been occasioned by the wrongful act of another. The plaintiff, when it settled with Murray, took from him a subrogation receipt,

* Decision rendered, June 10, 1916. 157 Pac. Rep. 1187. Syllabus by the Court.

which assigned to it all claims which he might have against the railway company to the extent of the insurance paid by the plaintiff. It was stated in the receipt that Murray had not, at that time, released the railway company from any liability on account of the loss. The insurance company promptly notified the railway company that it had paid Murray and had been subrogated to his rights in the amount paid, and demanded reimbursement. Subsequently, with full knowledge of these facts, the railway company made a settlement with Murray outside court, and paid him the sum of \$1,000, taking a receipt in settlement. This was done without the knowledge or consent of the insurance company. The plaintiff demanded that Murray prosecute this action in his own name, or join in the prosecution thereof, but he refused on the ground that he had settled all claims he had against the railway company. The plaintiff then brought the action, and joined Murray as a party defendant. The petition alleged the foregoing facts, and stated that Murray was made a defendant in order that the railway company might be protected and the entire matter litigated in one action. The petition also contained a statement that the only claim still existing against the defendant railway company on account of the loss was that held by the plaintiff by way of subrogation. Murray filed a disclaimer, in which he disclaimed all interest in any claim for damages against the railway company by reason of the facts alleged in the petition. The defendant railway company demurred to the petition, and the court sustained the demurrer, and this is the ruling complained of in plaintiff's appeal.

[1] The defendant claims that plaintiff cannot recover because no one but Murray himself can maintain the action since his loss exceeds the insurance. The defendant relies upon the rule as stated in *Railroad Co. vs. Insurance Co.*, 59 Kan. 432, 434, 53 Pac. 459, 460, where it was said:—

"When the loss does exceed the amount of the insurance, so that payment under the insurance contract constitutes but a partial satisfaction of the damages sustained, leaving a residue to be made good by the wrongdoer, a question has arisen as to whether the action against the wrongdoer for the recovery of the portion paid by the insurer should be undertaken in the name of the insurer or of the assured. The tendency of the courts seems to be to hold the latter to be the only competent person to bring suit. This upon the theory that an action for damages for a tort is indivisible and cannot be split up. In such cases the assured sustains toward the insurer the relation of trustee, in respect of such portion of the amount recovered as the former under his contract has been compelled to pay."

While that is the general rule, there are undoubtedly exceptions to it. The rule itself rests upon the right of the wrongdoer not to have the cause of action against him split up so that he is compelled to defend two actions for the same wrong. This is avoided by having the suit brought in the name of the insured,

who sues for himself and as trustee for the insurance company; but it would be manifestly contrary to right and justice to say that the arbitrary refusal of the insured to bring the action or to permit his name to be used as plaintiff could have the effect of depriving the insurance company of its right of subrogation or of all remedy to enforce that right. The plaintiff has pursued the proper course in this situation by bringing the action in its own name and joining the insured as a defendant. This allows the whole controversy to be settled in one action, and whatever rights the insured may have against the railway company will be adjudicated and determined in one action.

[2] The plaintiff has a right to maintain the action in this way under the provision of section 5629, General Statutes of 1909 (Code Civ. Proc. § 36), which reads:—

"Of the parties to the action, those who are united in interest must be joined, as plaintiffs or defendants; but if the consent of one who should have been joined as plaintiff cannot be obtained, he may be made a defendant, the reason being stated in the petition."

This provision of the Code is designed to take the place of the old common-law procedure by which the action would have been brought in the name of the insured to the use of the insurance company. In *Insurance Co. vs. Cosgrove*, 85 Kan. 296, 116 Pac. 819, 41 L. R. A. (N. S.) 719, on rehearing, 86 Kan. 374, 121 Pac. 488, it was said that the insurer "had three remedies to protect his rights, two before and one after the settlement was effected." Here the insurance company, having been notified of the pendency of the action, might have intervened therein, or it might have enjoined the pending settlement, "or the insurer might, after the settlement, have treated the settlement as void and have brought an action, in the name of the insured, against the railroad company for the amount it had paid the assured under the policy." *Insurance Co. vs. Cosgrove*, 86 Kan. 374, 375, 121 Pac. 488.

Aside from anything said in those opinions, however, this case may be decided on the provision of the Code above quoted, and on the ground, further, that the insured could not deprive the insurer of its right to subrogation by his arbitrary refusal to have the suit brought in his name.

It was error to sustain the demurrer, and the cause will be remanded for further proceedings All the Justices concurring.

**SUPREME JUDICIAL COURT OF MASSACHUSETTS.
MIDDLESEX.**

DOHERTY ET AL.

vs.

PHENIX INS. CO.*

4. INSURANCE—CANCELLATION OF POLICY—JURY QUESTION.

Whether a certain policy had been canceled prior to a fire held under the evidence a question for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1734, 1755; Dec. Dig. § 668[3].)

5. INSURANCE—ACTION ON AWARD—CONDITIONS PRECEDENT.

Under St. 1907, c. 576, § 60, as amended by St. 1911, c. 406, in an action on insurance policies to recover the amount fixed by an award, plaintiff must prove a valid award as a condition precedent to recovery.

(For other cases, see Insurance, Cent. Dig. §§ 1522-1528; Dec. Dig. § 612[3].)

6. INSURANCE—ARBITRATION AND AWARD.

Arbitrators or appraisers elected to determine controverted questions of fact should be disinterested and impartial, unless by mutual understanding they are intentionally selected as partisans.

(For other cases, see Insurance, Cent. Dig. § 1426; Dec. Dig. § 570.)

7. INSURANCE—ARBITRATORS—MISCONDUCT.

The award of arbitrators fixing the insurance loss may be impeached on the ground of misconduct of the arbitrators without resort to a bill in equity to set aside the award.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432, 1434; Dec. Dig. § 574[7].)

8. INSURANCE—ARBITRATORS—CONCLUSIVENESS OF AWARD.

Where the submission of a loss under an insurance policy to arbitrators contains no restrictions or conditions, their decision on all necessary questions of law and their findings of fact involved are final.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432, 1433; Dec. Dig. § 574[5].)

9. INSURANCE—AWARD—PARTIALITY OF ARBITRATOR—OBJECTION.

The defeated party cannot object to an award where, knowing of the existence of conditions which may influence the judgment of an arbitrator or referee or having notice of the partiality of one or more of the referees, sufficient to put him on inquiry, he remains silent.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432; Dec. Dig. § 574[3].)

* Decision rendered, May, 1916. 112 N. E. Rep. 940.

10. INSURANCE—ARBITRATION—MISCONDUCT OF ARBITRATORS.

The entertainment of an arbitrator or referee by one of the interested parties ordinarily is censurable, and may be so flagrant as to require the setting aside of the award.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432; Dec. Dig. § 574[3].)

11. INSURANCE—ARBITRATION—MISCONDUCT OF ARBITRATORS.

Evidence that plaintiff in entertaining arbitrators acted openly without concealment, and with no corrupt intention to induce a favorable decision, and that referees accepted the entertainment only as an unimportant courtesy and were not influenced thereby, but acted in good faith, held sufficient to warrant the jury in finding the award not invalidated by such conduct.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432, 1434; Dec. Dig. § 574[7].)

12. INSURANCE—ACTION ON POLICY—EVIDENCE OF LOSS.

Speculative, collateral, and immaterial offers to prove the value of insured drawings and patterns held properly excluded.

(For other cases, see Insurance, Cent. Dig. § 1695; Dec. Dig. § 660.)

14. INSURANCE—AWARD—EVIDENCE.

Where all the testimony received by the referees was not offered on the trial, a portion thereof is insufficient to enable the jury to determine whether the referee committed such gross mistakes of overvaluation as to show misconduct.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432, 1434; Dec. Dig. § 574[7].)

18. INSURANCE—ACTIONS—INSTRUCTIONS—SUFFICIENCY.

Instructions examined, and held properly to present the law on the question of whether an award of arbitration on insurance policies was free from fraud, bias, prejudice, or misconduct on the part of the arbitrators, and whether the award was so grossly excessive as to imply fraud, bias, or prejudice.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432, 1434; Dec. Dig. § 574[7].)

Exceptions from Superior Court, Middlesex County; Patrick M. Keating, Judge.

Consolidated actions by William C. Doherty and others against the Phoenix Insurance Company, against the Connecticut Fire Insurance Company, against the Springfield Fire & Marine Insurance Company, against the Scottish Union & Nat. Insurance Company, against the St. Paul Fire & Marine Insurance Company, against the Sun Insurance Company, against the New Hampshire Fire Insurance Company, against the Liverpool & London & Globe Insurance Company, Limited, against the Phoenix Assurance Company, Limited, against the Firemen's Insurance Company of Newark, N. J., against the Hartford Fire Insurance Company, against the Norwich Union Fire Insurance Company, Limited, and against the Massachusetts Fire & Marine Insurance Company. Verdict for plaintiffs, and defendants except. Exceptions overruled.

John M. Maloney and Frank J. Maloney, both of Boston, for Plaintiffs.
Brown & Came, of Boston, for Defendants.

BRADLEY, J.

The plaintiffs seek to recover in thirteen separate actions, for loss of property covered by policies of fire insurance issued by the respective defendants. By order of the trial court the cases were tried together; and verdicts having been returned for the plaintiffs in each case, the defendants presented and the judge allowed one bill of exceptions, stating in his certificate that the plaintiffs contended that each defendant should have presented a separate bill of exceptions, and as this had not been done the exceptions were not seasonably filed and should be disallowed.

[1] It was his duty either to allow or disallow the exceptions, giving if he deemed necessary his reasons in the certificate, and if allowed the plaintiffs could move in this court that the exceptions be dismissed for want of jurisdiction. *Conway vs. Callahan*, 121 Mass. 165; *Cooney vs. Burt*, 123 Mass. 579; *Hale vs. Rice*, 124 Mass. 292; *Browne vs. Hale*, 127 Mass. 158; R. L. c. 173, § 106.

The motion to dismiss on this ground filed in the trial court, although fully set forth in the certificate, has never been passed upon and cannot be considered. But inasmuch as the question whether the exceptions were properly allowed is presented by the certificate, and has been argued by counsel, it should be decided.

[2] The actions although brought for different causes are for the recovery of one loss common to all the policies, and with the exception that the verdicts, judgments and rescripts must be separate, a joint trial undoubtedly tended to benefit the parties saving costs and expenses and preventing delay, as well as tending to lessen the possibility of mistrials. *Lumiansky vs. Tessier*, 213 Mass. 182, 188, 99 N. E. 1051, Ann. Cas. 1913E, 1049.

If these considerations were sufficient to justify the order of a joint trial before a jury, we perceive no sufficient reason why questions of law cannot be presented to this court by a single bill of exceptions wherein all parties aggrieved are joined. Indeed this practice has often been recognized and sanctioned without comment. *Locke vs. Royal Ins. Co.*, 220 Mass. 202, 107 N. E. 911; *Whitcomb vs. Boston Dairy Co.*, 218 Mass. 24, 105 N. E. 554; *Christiansen vs. Lannin*, 215 Mass. 322, 102 N. E. 419; *Rockwell vs. Hamburg-Bremen Fire Ins. Co.*, 212 Mass. 318, 98 N. E. 1086; *Greenough vs. Phoenix Ins. Co. of Hartford*, 206 Mass. 247, 92 N. E. 447, 138 Am. St. Rep. 383; *Parker vs. Middlesex Assurance Co.*, 179 Mass. 528, 61 N. E. 215.

The exceptions being properly here, we come to the questions raised by the record.

While conceding that the policies were in force at the date of the fire, and that proper proofs of loss had been furnished, and that referees to ascertain the amount of loss had been chosen as provided in each policy and awards had been made, the defendants

having declined to accept the awards rested their defense on the grounds stated in the following issues:—

"Whether or not the plaintiff set the fire in question or caused it to be set;" "whether or not the award of the referees * * * was valid," and "whether or not a certain policy which had been issued by the London Assurance Corporation and which purported to cover plans, patterns, drawings and blue prints for \$1,500 and the machines and parts of machinery for \$1,000 had been legally canceled before the fire."

And these issues properly phrased having been submitted to the jury they answered the first in the negative; and the second and third in the affirmative.

It will be convenient to dispose of the first and third issues before considering the second issue around which the principal controversy centers.

[3] The brief of counsel for the defendants states:—

"That the evidence which tended to show that the plaintiff William C. Doherty set the fire in question is not set forth in the bill because it seemed to us to have no bearing on the only exception which he took relative to the matter, and because from the fact that the question was left to the jury, it is to be presumed there was evidence to justify it."

But this assumption of wrongful conduct cannot be made, and in the absence of such evidence as a foundation, the relevancy of the offer of proof which was excluded and is the sole exception under this issue cannot be ascertained and determined. *Paquette vs. Prudential Life Ins. Co.*, 193 Mass. 215, 222, 79 N. E. 250; *Barron vs. International Trust Co.*, 184 Mass. 440, 68 N. E. 831; *Whittemore vs. N. Y., N. H. & H. R. R.*, 191 Mass. 392, 77 N. E. 717.

[4] The judge also rightly declined to rule, that there was no evidence from which the jury could find the policy issued on the property by the London Assurance Corporation had been canceled, and that, if the policies issued by the defendants were in force, then the policy of that company was also in full force and effect.

It was for the jury under suitable instructions which were given, to determine from the letter of the company's agent to the plaintiffs demanding at the request of the company the policy for cancellation, and from what occurred at a subsequent interview between him and one of the plaintiffs, whether there had been a mutual agreement and understanding that the policy had been terminated. *Smith vs. Scottish Union Nat. Ins. Co.*, 200 Mass. 50 57, 85 N. E. 841; *Bennett vs. City Ins. Co.*, 115 Mass. 241, 243; *Alliance Mut. Ins. Co. vs. Swift*, 10 Cush. 433.

[5] The declarations having alleged, that in accordance with the requirements of the policies the amount of loss had been fixed by referees who have made their award in writing, and that upon making the award each of the defendants became bound to pay

its proportionate part of the loss, the plaintiffs were required to offer evidence of a valid award as a condition precedent to recovery. St. 1907, c. 576, § 60, as amended by St. 1911, c. 406. Union Ins. for Savs. vs. Phoenix Ins. Co., 196 Mass. 230-234, 235, 81 N. E. 994, 14 L. R. A. (N. S.) 459, 13 Ann. Cas. 433; Hanley vs. Aetna Ins. Co., 215 Mass. 425, 431, 102 N. E. 641, Ann. Cas. 1914D, 53; Second Soc. of the Universalists vs. Royal Ins. Co., 221 Mass. 518, 109 N. E. 384.

[6,7] It is the general rule even if the letter, properly admitted in evidence, of plaintiffs' counsel replying to a letter from defendants' counsel previously introduced tends to show a contrary practice, that referees or arbitrators clothed with authority and the power of deciding controverted questions between party and party should be disinterested and impartial unless with the mutual understanding of the parties they are purposely selected as partisans. Hills vs. Home Ins. Co., 129 Mass. 345; Hanley vs. Aetna Ins. Co., 215 Mass. 425, 430, 102 N. E. 641, Ann. Cas. 1914D, 53; Morville vs. Am. Tract Soc., 123 Mass. 129, 140, 25 Am. Rep. 40; Williams vs. Chicago, Sante Fe & Cal. Ry., 112 Mo. 463, 486, 489, 20 S. W. 631, 34 Am. St. Rep. 403. And the defendants under our law can impeach an award on the ground the referees were guilty of misconduct, instead of resorting to a bill in equity to have it set aside. Bean vs. Farnam, 6 Pick. 269, 273.

[8] The jury would have been warranted in finding that the plaintiffs voluntarily paid for "lunches" furnished to the referees and offered them cigars, and that at the hearings testimony as to the amount of premiums paid for insurance was admitted in evidence, and plaintiffs' counsel were permitted to argue that the defendants' agent by whom the insurance was solicited knew the cost to the plaintiffs of the insured property and that a large amount in premiums having been paid the defendants were guilty of fraud if they declined payment of the loss suffered. But the error, if error there was in the admission of evidence and in the scope allowed counsel in argument, is not reviewable. The referees were unhampered by any restrictions or conditions and their decisions on all necessary questions of law, and their findings of fact involved in the question or controversy submitted, are final. Bigelow vs. Newell, 10 Pick, 348; Boston Water Power Co. vs. Gray, 6 Metc. 131; Smith vs. B. & M. R. R., 16 Gray, 521; Rundell vs. La Fleur, 6 Allen, 480; Mickles vs. Thayer, 14 Allen, 114; Gardner vs. Boston, 120 Mass. 266, 267; Goodman vs. Sayres, 2 Jac. & W. 249, 259.

[9] It is also settled that where the defeated party is aware of the existence of conditions which may influence the judgment of an arbitrator or referee, or previous to the hearing has sufficient notice of the partiality of one or more of the referees to put him upon inquiry but remains silent, he cannot afterwards object to the award or report on the ground of partiality. Fox vs. Hazel-

ton, 10 Pick. 275, 277; New England Trust Co. vs. Abbott, 162 Mass. 148, 153, 38 N. E. 432, 27 L. R. A. 271; Moseley vs. Simpson, L. R. 16 Eq. 226.

The furnishing of the first luncheon was with the knowledge of the defendants' counsel who made no objection to proceeding before the referees, but until the day after the award had been published counsel did not know of the second luncheon at which cigars also were supplied.

[10, 11] The entertainment of an arbitrator or referee by one of the interested parties ordinarily is censurable. It may be so flagrant in character as to justify and require the setting aside of the award. See Robinson vs. Shanks, 118 Ind. 125, 20 N. E. 713. But the jury to whom in the case at bar this question was rightly left could find, that there was no concealment by the plaintiffs on either occasion, and that they did not act corruptly or with the intention of inducing the referees to decide in their favor, and that the referees accepted the hospitality only as a courtesy, not deeming the occasion, as one of them a witness for the defendants was properly permitted to state in cross-examination, of any importance, and that the referees had not been influenced thereby but acted throughout the proceedings in good faith. Brown vs. Bellows, 4 Pick. 179, 192; Strong vs. Strong, 9 Cush. 560; Farrell vs. German Ins. Ass'n, 175 Mass. 340, 347, 56 N. E. 572; Morville vs. American Tract Soc., 123 Mass. 129, 139, 140, 141, 25 Am. Rep. 40; Liverpool & London & Globe Ins. Co. vs. Goehring, 99 Pa. 13; Crossley vs. Clay, 5 C. B. 581; Hopper vs. Wrightson, L. R. 2 Q. B. 367, 374.

[12, 13]. The policies having insured the patterns, drawings, models, jigs, and blueprints and printed matter pertaining to the manufacture of planers and other machinery, and also all the fixed and movable machinery and machines with extra and spare parts of the same and the shafting, belting, pulleys and hangers which were contained in the plaintiffs' three story frame building, basement and additions, and the defendants having pleaded that the award was so grossly in excess of the actual amount of the loss as to show that the referees must have been biased or acted corruptly, a large amount of evidence as to the value of the property at the time of the fire was introduced by the parties. But offers of proof by the defendants, that the style of planers to be manufactured by the plaintiffs, and the drawings and patterns therefor had been greatly diminished in value because other planers of alleged improved types had been put upon the market, and of the cost to the plaintiffs of manufacturing the planers and the time required and the number of men who necessarily must be employed, and the percentage of planers made by other manufacturers, and the place in which the plaintiffs' drawings and models were stored, or whether they could have been put in a safe, or why if of great value the plaintiffs did not keep them in a safe place, were so re-

mote, speculative, collateral and immaterial as bearing on the question of the value of the insured property as well as tending to confuse the jury and direct their attention from the material issues upon which they were to pass, that their exclusion was within the sound discretion of the judge. Abbott vs. Shepard, 142 Mass. 17, 21, 6 N. E. 826; Anthony vs. New York, Providence & Boston R. R., 162 Mass. 60, 37 N. E. 780; Dolan vs. Boott Cotton Mills, 185 Mass. 576, 579, 70 N. E. 1025. The exclusion in cross-examination of a witness called by the plaintiffs of a question calling for his recollection of what a witness had said before the referees, and of a question to one of the plaintiffs if he testified before the referees substantially as he had at the trial and also "something more than at the trial" and of a copy of the brief for the defendants submitted to the referees, does not appear to have prejudiced the substantive rights of the defendants. Worrell vs. Baldwin Chain & Mfg. Co., 222 Mass. 355, 110 N. E. 967; St. 1913, c. 716, § 1.

[14] It furthermore does not appear that all the evidence introduced by both parties before the referees was offered at the trial, and a portion is manifestly insufficient to enable a jury to determine whether the referees committed such gross mistakes of overvaluation as to show misconduct. Brown vs. Bellows, 4 Pick. 179, 192; Bell vs. Price, 21 N. J. Law, 32, 36, 37, 38. The jury on the evidence submitted to them were to decide under suitable instructions whether the total amount awarded was so grossly in excess and out of all proportion to the actual loss sustained, as to show when viewed in connection with the other allegations of misconduct, that there was fraud or partiality on the part of the referees.

[15, 18] It being plain for reasons previously stated that on its face the award as matter of law was not invalid on either ground alleged, and could only be impeached by extrinsic evidence, the request that a verdict for the defendants be ordered could not have been given. It is sufficient to say, that the plaintiffs not having contended that the demand by the defendants for resubmission had been waived, the requests relating thereto were immaterial, while full and accurate instructions were given that the plaintiffs could not recover unless the award was found to be valid. The judge was not required to give the requests based on particular portions of the evidence. Moseley vs. Washburn, 167 Mass. 345, 362, 45 N. E. 753. And the plaintiffs' requests to the giving of which the defendants excepted were correct and appropriate. Washington Mills Mfg. Co. vs. Weymouth Ins. Co., 135 Mass. 503; Farrell vs. German Am. Ins. Co., 175 Mass. 341, 56 N. E. 572; Hanley vs. Aetna Ins. Co., 215 Mass. 425, 102 N. E. 641, Ann. Cas. 1914D, 53. The defendants also excepted to the instructions. It was unnecessary for the judge to recite the evidence. The jury were told:—

"If you find that in the making of this award there was fraud on the part of one or more referees, or bias or prejudice, or that there was misconduct on the part of Doherty or some one else that influenced one or more of the referees in the making of the award, then the award would not be valid. But if you find that these referees acted honestly and with a desire to arrive at a just and correct result, then the award would be valid. That is to say, gentlemen, if you find that the referees were free from bias, prejudice or fraud in the making of the award and that there was no misconduct on the part of the plaintiff or anybody else that influenced them in the making of the award, then you will be justified in finding the award was valid.

"One of the grounds on which the defendants base their claims, is that they allege the award was grossly excessive. The plaintiffs deny that the award was excessive. The plaintiffs claim that the actual value of the insured property at the time of the fire was in excess of the amount of the award, so it becomes necessary for you to ascertain whether the amount of the award was excessive.

"Even if you should find that the award was excessive that would not be sufficient to warrant you in finding that because of that circumstance alone there was fraud, bias or prejudice on the part of any of the referees. It is only when the award is so grossly and palpably above the actual loss as to afford intrinsic evidence of fraud, bias or prejudice on the part of one or more of the referees that you would be warranted in finding that there was fraud, bias or prejudice on the part of one or more of the referees because the award was in excess of the actual value of the insured property."

The charge is to be considered as a whole, and without further review the law by which the jury were to be guided was correctly and clearly stated. *Conners Bros. Co. vs. Sullivan*, 220 Mass. 600, 108 N. E. 503.

We have considered all the exceptions in so far as argued and finding no reversible error the order must be:—

Exceptions overruled.

COURT OF APPEALS OF NEW YORK.

HUDSON

vs.

GLENS FALLS INS. CO.*

1. INSURANCE—FIRE INSURANCE—INSURABLE INTEREST—NOTICE—EFFECT.

Where plaintiff, on securing additional insurance on hay, informed the insurer's agents that he had a contract with his landlord under which title to the hay remained in the landlord until plaintiff performed his lease covenants, whereupon he was to have half the hay remaining after leaving sufficient to winter certain stock, the policy was valid, notwithstanding plaintiff's qualified ownership.

(For other cases, see Insurance, Cent. Dig. §§ 968, 975-997; Dec. Dig. § 378[1].)

2. INSURANCE—FIRE INSURANCE—INSURABLE INTEREST—QUALIFIED OWNERSHIP.

Where plaintiff had a contract with his landlord under which title to the hay remained in the landlord until plaintiff performed his lease covenants, whereupon he was to have half the hay remaining after leaving sufficient to winter certain stock, he had an insurable interest in the hay, since he might hold it against all the world except the landlord, and could even collect the insurance money and then account to the landlord.

(For other cases, see Insurance, Cent. Dig. § 147; Dec. Dig. § 115[4].)

5. INSURANCE—DISCHARGE—FRAUD—RIGHTS OF INSURED—“MATERIAL FACT.”

Where a tenant disclosed to the insurer's agent that he and the landlord had a contract by which title to certain hay remained in the landlord until performance by the tenant of his lease covenants, and the insurer issued its policy in favor of the tenant, but on loss its adjuster represented to the tenant that the policy was void as to the hay, when, in fact, it was valid, and the tenant relied on such representation and settled for less than the loss, the representation was of a “material fact,” so as to entitle the tenant to rescind the contract of settlement and sue for the entire loss.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432; Dec. Dig. § 574[3].)

(For other definitions, see Words and Phrases, First and Second Series, Material Fact.)

Appeal from Supreme Court, Appellate Division, Fourth Department.

Action by Charles Hudson against the Glens Falls Insurance Company. From a judgment of the Supreme Court, Appellate Division (162 App. Div. 934, 147 N. Y. Supp. 1117), reversing a judgment of the Special Term for plaintiff, entered upon a referee's report, and dismissing the complaint, plaintiff appeals. Reversed, and judgment on referee's report reinstated.

John Conboy, of Watertown, for Appellant.
Virgil K. Kellogg, of Watertown, for Respondent.

* Decision rendered, May 2, 1916. 112 N. E. Rep. 728.

CUDDEBACK, J.

The action was brought to rescind a contract whereby the parties adjusted and settled a claim of the plaintiff on a policy of fire insurance.

The plaintiff was working a farm on shares. His contract with the owner of the farm provided for keeping thereon fifty cows, the property of the farm owner, and six horses to be furnished by the plaintiff for doing the farm work. The cows and horses were to be fed on the hay produced on the farm before a division thereof between the parties was made. The contract began on January 1, 1912, and was to continue for one year. The plaintiff was to leave on the farm at the expiration of his contract a sufficient quantity of hay to feed the cows, and also to feed six horses, until the time came in the spring when they could be turned out to grass. The contract also contained a provision that the title to all the crops raised on the farm during the continuance of the contract, and the products of the dairy, should be in the owner of the farm as security for the performance of the contract by the plaintiff until he had fully performed, and then a division between the parties should be made.

On May 8th following the date of the agreement the plaintiff procured from the defendant's agent a policy of fire insurance, in the standard form of this state, insuring his horses, wagons, and farm implements. On the 5th day of August, after the crop of hay had been gathered, the plaintiff, by a rider attached to the same policy, procured further insurance from the defendant's agents on the hay and other products of the farm.

The referee found upon sufficient evidence, and the finding was not disturbed by the Appellate Division, that when the last insurance was procured the defendant's agents were informed that the hay which was insured was held by the plaintiff under the terms of the aforesaid contract between the plaintiff and the owner of the farm as to the title of the latter to the farm produce. On August 26th the barn in which the hay was stored and its contents were totally destroyed by fire. The controversy here is over the loss on the hay.

A few days after the fire the defendant's adjuster visited the farm for the purpose of adjusting the plaintiff's loss, and, as the referee found upon sufficient evidence, the adjuster informed the plaintiff that the policy as to the hay at least was void, because the plaintiff was not the owner thereof when it was insured, and that his only interest was in the surplus that would remain after the stock on the farm had been turned out to grass according to the contract. The referee's finding in that respect has not been disturbed by the Appellate Division. No controversy arose between the plaintiff and the defendant's adjuster over losses on the other property covered by the policy of insurance.

The Appellate Division, in reversing the judgment in favor of the plaintiff, struck out the finding by the referee that the state-

ment made by the adjuster at the time of the settlement was a misrepresentation of both law and fact, but, as has been already said, the court did not disturb the specific finding of the referee as to what the adjuster did say. The Appellate Division further held that the plaintiff "had no insurable interest in that part of the hay destroyed which was necessary to winter out the stock."

[1] I think the Appellate Division was in error in both the propositions which it decided, and that the statement made by the adjuster to the plaintiff at the time of the settlement was a material misrepresentation, and also that the plaintiff did have an insurable interest in the hay. The fact as found by the referee that the defendant's agents who issued the policy were informed of the provisions of the contract between the plaintiff and the owner of the farm regarding the title to the farm products is sufficient to validate the insurance, notwithstanding the qualified ownership of the plaintiff which the contract disclosed. *Robbins vs. Springfield Fire & M. Ins. Co.*, 149 N. Y. 477, 44 N. E. 159; *Skinner vs. Norman*, 165 N. Y. 565, 59 N. E. 309, 80 Am. St. Rep. 776; *Haight vs. Continental Ins. Co.*, 92 N. Y. 51. The policy of insurance was not therefore issued upon any misunderstanding as to the ownership of the hay.

[2] The plaintiff had an insurable interest in all the hay destroyed, including that "which was necessary to winter out the stock." The court at the Appellate Division apparently did not deny that the plaintiff had an insurable interest in so much of the hay as was necessary to feed the cows and his horses prior to the expiration of the contract on January 1, 1913. Whether any part of the hay would then remain was perhaps uncertain, but the plaintiff was in possession of all the hay, and he could hold it against all the world, except the owner of the farm. Furthermore, he could insure the hay for his own protection and for the protection of the owner of the farm, and in case of loss he could collect the whole amount of the insurance moneys and account to the farm owner for his part thereof, if there was any part which belonged to him. The defendant's agents, as has been said, had full knowledge of the extent of the plaintiff's interest in the hay. Under all these circumstances the plaintiff had the right to take out the policy. *Waring vs. Indemnity Fire Ins. Co.*, 45 N. Y. 606, 611 (6 Am. Rep. 146). In that case the court said:—

"It is laid down in broad terms that one may, in his own name, insure the property of another for the benefit of the owner without his previous authority or sanction, and that it will inure to the benefit of the owner upon a subsequent adoption of it, even after a loss has occurred."

The court further said, with regard to persons taking out such insurance, that:—

They may "recover of the insurer not only a sum equal to their own interest in the property by reason of any lien for advances

or charges, but the full amount named in the policy up to the value of the property."

[3, 4] The general rule is that under a contract to work a farm on shares the parties become tenants in common of the crops. *Reynolds vs. Reynolds*, 48 Hun, 142. That would be the case here but for the provision in the contract that the title to the crops should be in the owner of the farm as security for the faithful performance of the contract by the plaintiff until he had fully performed the same. These provisions amounted to a mortgage given by the plaintiff to the owner of the farm on the hay produced. The plaintiff, under well-settled rules, had an insurable interest in the hay notwithstanding the title in the owner of the farm. *Berry vs. Am. Central Ins. Co.*, 132 N. Y. 49, 30 N. E. 254, 28 Am. St. Rep. 548; *Nugent vs. Rensselaer County Mutual Fire Ins. Co.*, 106 App. Div. 308, 94 N. Y. Supp. 605.

[5] It appears plainly enough that the misrepresentations made by the adjuster to the plaintiff after the loss that the insurance on the hay was void misled the latter to his injury. *Berry vs. Am. Central Ins. Co.*, supra, resembles in many respects the case under consideration. The court there said:—

"The plaintiff was a man of little business experience, although he had education enough to understand the transaction and read the papers which he signed, and he made the settlement voluntarily, without any coercion upon him, but relied upon the representations as to the law governing his case which the defendant falsely made to him. There is no question, of course, but that a court of equity cannot grant relief solely upon a mistake of law. But there was here more than a mistake. There was a surrender of legal rights intentionally induced and procured by a false representation as to the law governing the case. The defendant must be presumed to have known that it was liable for the whole loss, and by falsely representing that under the law applicable to the case the policy was void, when, in fact, it was valid, it induced the plaintiff to rely upon the superior knowledge that it possessed upon the subject and to surrender to it his claim."

See, also, *Haviland vs. Willets*, 141 N. Y. 35, 35 N. E. 958; *Greene vs. Smith*, 160 N. Y. 533, 55 N. E. 210; Pomeroy's *Eq. Juris*. vol. 2 (2d Ed.), § 847.

The court here found that the plaintiff was a young man 26 years of age of quite limited business experience, and that he believed and relied upon the false statements of the defendant's adjuster that the policy was void as to the hay, and that he was thus induced to accept, and did accept, the offer for a less amount than the loss sustained. The case is within the principle laid down in *Berry vs. Am. Central Ins. Co.*, supra.

The conclusion is that the judgment of the Appellate Division should be reversed, with costs, and the judgment entered upon the report of the referee should be reinstated.

Willard Bartlett, C. J., and Hiscock, Chase, Hogan, Cardozo, and Pound, JJ., concur.

Judgment reversed, etc.



SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FOURTH DEPARTMENT.

SALZANO

vs.

MARINE INS. CO., LIMITED.*

1. INSURANCE—BROKER—AGENCY FOR APPLICANT—STATUTES—“AGENT.”

In action for loss upon foreign fire insurance policy, the defense being that policy was issued on false representations by plaintiff, held, plaintiff was bound by his representations as made to defendant in application prepared by the broker who solicited the insurance, since such broker was in that respect the agent of plaintiff, notwithstanding Insurance Law (Consol. Laws, c. 28) § 49, providing that the term “agent” in that chapter shall include “any person who shall in any manner aid in transacting the insurance business of any insurance corporation not incorporated by the laws of this state and any broker whose business is to negotiate for and place risks.”

(For other cases, see Insurance, Cent. Dig. § 126; Dec. Dig. § 96.)

(For other definitions, see Words and Phrases, First and Second Series, Agent.)

2. INSURANCE—ESTOPPEL—KNOWLEDGE OF AGENT—WHO IS AGENT.

Knowledge or notice of the falsity of such representations received by such broker in the course of soliciting plaintiff to insure, preparing plaintiff's application, or negotiating for the policy is not to be imputed to defendant.

(For other cases, see Insurance, Cent. Dig. §§ 971, 973, 974, 977-997; Dec. Dig. § 378[2].)

Appeal from Trial Term, Erie County.

Action by Rose Salzano against the Marine Insurance Company. From a judgment for plaintiff, and from an order denying new trial on the court's minutes, defendant appeals. Reversed, and new trial ordered.

See, also, 165 App. Div. 949, 150 N. Y. Supp. 1111.

Argued before Kruse, P. J., and Foote, Lambert, Merrell, and De Angelis, JJ.

Frank Gibbons and Gibbons & Pottle, all of Buffalo, for Appellant. Charles W. Sickmon and Armstrong & Jackson, all of Buffalo, for Respondent.

* Decision rendered, April 19, 1916. 159 N. Y. Supp. 277.

FOOTE, J.

Plaintiff has recovered upon a policy of insurance for damage to her automobile by fire. The policy contained a clause making it void "if the insured has concealed or misrepresented in writing or otherwise any material fact or circumstance concerning this insurance or the subject thereof." One of the defenses was the alleged misrepresentations of plaintiff's agent as to the year of manufacture and the cost of the car to plaintiff. A Mr. Kennedy was an insurance broker in Buffalo. He had in his employ as a solicitor one Mooney, who solicited plaintiff, through her agent, to insure her automobile. Defendant is a foreign insurance company, with its head office in London, England. Chubb & Son, of New York City, are its general agents in this country, and a Mr. Walsh is its local agent in Buffalo. Mooney obtained from plaintiff, through her agent, a written application to defendant company for a policy of \$1,500. It was stated in the application that the car was made in 1908 and cost plaintiff \$2,300. Both of these statements were false. The car was made in 1907 and put into use in June of that year, and it was bought by plaintiff as a second-hand car for \$850. She expended some money for repairs, but the total cost to her, including repairs, was less than the sum stated by several hundred dollars.

There have been two trials of the case. On the first trial the jury were instructed that Kennedy and Mooney were brokers, and were plaintiff's agents, and that plaintiff was bound by the statements contained in the written application which Mooney wrote from information given him by plaintiff's agent, but it was left to the jury to say whether the facts so falsely stated in the application were material to the risk. The jury found for the plaintiff that they were not, and this court sustained defendant's exceptions and directed a new trial, holding that the policy was procured through misrepresentations of plaintiff's agent as to the material facts as to the cost of the car to plaintiff and the year of its manufacture. *Salzano vs. Marine Ins. Co.*, 165 App. Div. 949, 150 N. Y. Supp. 1111. On the second trial, now under review, the jury were instructed in effect that the statements in the written application as to the cost of the car to plaintiff and the year of its manufacture were in fact false and material; that if these facts were so stated to Mooney by plaintiff's agent at the time Mooney wrote them in the application, plaintiff could not recover; that Mooney and his employer, Kennedy, the broker, were defendant's agents, and not agents of plaintiff, and if plaintiff's agent stated to Mooney correctly the cost of the car to plaintiff and the year of its manufacture, and if Mooney was responsible for writing these facts in the application incorrectly, then plaintiff was not responsible for that and could recover.

It is said that the learned judge who presided at both trials was led to hold upon the last trial that Kennedy and Mooney were

defendant's agents, contrary to his ruling upon the first trial, because section 49 of the Insurance Law required him to so hold. This section (chapter 33, Laws 1909, being chapter 28 of the Consolidated Laws) is as follows:—

"Sec. 49. Every agent of any insurance corporation doing business in this state shall, in all advertisements of such agency, publish the location of the corporation, giving the name of the city, town or village in which it has its principal business office, and the state or government under the laws of which it is organized. The term 'agent' in this chapter shall include an acknowledged agent or surveyor or any other person who shall in any manner aid in transacting the insurance business of any insurance corporation not incorporated by the laws of this state, and any broker whose business, in whole or in part, is to negotiate for and place risks, deliver the policies covering the same and collect premiums therefor."

[1, 2] The question is whether Kennedy and Mooney, acting as brokers for plaintiff to place her insurance, became, by force of this section, agents for the defendant company, so that it became chargeable as matter of law with the knowledge or notice which they may have had, but which they did not communicate to defendant. I do not think such was the legislative intent, or that the language used imports such a meaning. The purpose of the statutory definition of the term "agent," contained in this section, appears to be, not to establish the relation of principal and agent as between a foreign insurance company and a person who seeks to place with it insurance as broker for the insured, but rather to regulate and control the business of foreign insurance companies in this state. The language employed for that purpose is:—

"The term 'agent' in this chapter shall include * * * any broker whose business," etc.

There are many provisions in "this chapter" (the Insurance Law) which prohibit agents of foreign insurance companies from placing risks in this state until the laws here regulating such business have been complied with, and the intent is that these provisions shall apply equally to brokers and prohibit them from placing insurance where duly constituted agents would be prohibited from so doing. Some of the sections in which the term "agent" appears, and which, by force of section 49, must be held to include "broker," are as follows:—

By section 38, every agent who receives or collects any money as such is made responsible therefor in a fiduciary capacity. By section 50, no person shall act as agent for any foreign insurance company, or negotiate for risks, unless such company has complied with the provisions of the Insurance Law, and, if he does, is subject to a penalty. By section 134, agents for foreign insurance companies are prohibited from writing policies in any city or village until they have given to the treasurer of such city or village

a bond for the benefit of its fire department, conditioned to pay to such treasurer 2 per cent. of the premiums received as required by section 133. By section 137, the superintendent of insurance is authorized to license a limited number of agents to write under certain circumstances policies for companies not admitted to do business in this state. By section 142, agents are prohibited from acting as such without procuring a certificate of authority from the superintendent of insurance; and section 143 prohibits "brokers" from soliciting or procuring applications for insurance without procuring a like certificate of authority, and also defines the term "broker," as used in this section, to include any person who acts or aids in any manner on behalf of the insured in negotiating contracts of insurance, etc., for a consideration.

The terms of the statute as embodied in section 49 are, I think, given their full effect and meaning when the term "agent" appearing in the other sections above referred to, and perhaps in some others, is held to include "any broker whose business, in whole or in part, is to negotiate for and place risks, deliver the policies covering the same, and collect premiums therefor." By this construction foreign insurance companies which have not complied with our laws so as to be entitled to write insurance upon property in this state are prevented from evading the law by availing themselves of the services of brokers not commissioned as their agents to place policies in this state. The history of section 49 seems to support this construction. Its origin is found in part in section 7 of chapter 308 of the Laws of 1849, entitled "An act to provide for the incorporation of insurance companies." Section 7 contains provisions respecting companies incorporated in other states which seek to do business in this state, and among other things prohibits agents of such foreign insurance companies from doing business here without procuring a certificate of authority from the comptroller of this state after complying with certain requirements, and imposes a penalty upon such agents for its violation. The last sentence of the section is:—

"The term 'agent or agents' used in this section shall include an acknowledged agent or surveyor, or any other person or persons who shall in any manner aid in transacting the insurance business of any insurance company not incorporated by the laws of this state."

Chapter 466 of the Laws of 1853, entitled "An act to provide for the incorporation of fire insurance companies," contains in section 23 further provisions in reference to agents of foreign insurance companies seeking to write fire insurance in this state. This section closes with the same sentence above quoted from section 7 of the act of 1849, and contains also the following sentence, not found in that act:—

"Every agent of any fire insurance company shall, in all advertisements of such agency, publish the location of the company,

giving the name of the city, town or village in which the company is located, and the state or government under the laws of which it is organized."

As all the other provisions of this section apply expressly to foreign insurance companies, it is assumed that this clause was likewise so intended. By chapter 555 of the Laws of 1875 the above-mentioned section 23 of the act of 1853 was amended in several particulars. The two clauses above quoted from the act of 1853 remained unchanged, but there were added this provision:

"Whenever, by the provisions of this section, it shall be unlawful for any fire insurance company, association, or partnership, herein specified, to take risks, or transact the business of fire insurances within this state, through agents, or otherwise, it shall be likewise unlawful for any broker or brokers, or other persons acting for persons, firms or corporations, in this state or elsewhere, to negotiate for or place risks in any such insurance company, or in any way or manner, aid such persons, firms or corporations in effecting such unauthorized insurances. * * * And the term 'broker' or 'brokers,' also used in this section, is hereby declared to include all persons and firms whose business, in whole or in part, it is to negotiate for and place risks, deliver the policies covering the same, and collect the premiums therefor."

There was also added at the end of the section a clause to the effect that the section applied only to foreign insurance companies. In the revision of the Insurance Law by chapter 690 of the Laws of 1892, these quoted provisions from prior statutes were revised and brought into one section, numbered 49, in the form in which that section still remains. By section 292 of that act it is provided that:—

"The provisions of this chapter so far as they are substantially the same as those of laws existing on September 30, 1892, shall be construed as a continuation of such laws, modified or amended, according to the language employed in this chapter and not as new enactments."

All the provisions of section 49 as now in force are found in the above-mentioned section 23 as amended by chapter 555 of the Laws of 1875. In the revision of 1892 these provisions were consolidated into their present form, not, as I think, with intent to change their substance or meaning, but for the sake of brevity. There is nothing in said section 23, so consolidated and abbreviated, which purports to make brokers, "whose business in whole or in part it is to negotiate for and place risks, deliver the policies covering the same and collect the premiums therefor," agents of the insurance companies in which the risks are placed, even in the matter of delivering the policies and collecting the premiums.

In view of the history of this statute, I think the phrase, "and any broker whose business, in whole or in part, is to negotiate for and place risks," does not refer to such negotiations in behalf of

the company, but in behalf of the applicant for insurance whom the broker represents, and so, in any event, does not make the broker an agent for the company in such negotiations, even if he becomes the agent of the company to deliver the policies and collect the premiums. Under such construction, the company would not be chargeable with information which the broker received during negotiations, but only with such as he acquired in delivering the policy and collecting the premium. In negotiating for a policy in behalf of a person desiring insurance, the broker is the agent of that person, and not of the insurer. He cannot in that matter be the agent of both, as their interests conflict. *Northrup vs. Piza*, 43 App. Div. 284, 60 N. Y. Supp. 363, affirmed 167 N. Y. 578, 60 N. E. 1117; *Wilber vs. Williamsburgh, etc., Co.*, 122 N. Y. 439, 25 N. E. 926; *Wisotzkey vs. Hartford Co.*, 112 App. Div. 596, 98 N. Y. Supp. 763 (opinion by Spring, J.: dissenting opinion by McLennan, P. J.); *Allen vs. German Am. Ins. Co.*, 123 N. Y. 6, 25 N. E. 309; *Empire State Insurance Co. vs. American Central Ins. Co.*, 138 N. Y. 446, 34 N. E. 200; *Shepard vs. Davis*, 42 App. Div. 462, 59 N. Y. Supp. 456. He owes a duty to his employer to act in his interest, and not in the interest of the company. It would, I think, be a breach of his duty to his employer to disclose to the company any information he may have received from his employer which it would be against the interest of his employer to have disclosed. Moreover, the policy contains this clause:—

“22. No person shall be deemed an agent of this company, unless such person is authorized in writing as such agent of this company.”

This clause differs but slightly from the similar clause of the standard form of fire policy in this state, which is as follows:—

“In any matter relating to this insurance, no person, unless duly authorized in writing, shall be deemed the agent of this company.”

As the standard policy containing this clause is the creature of statute, effect must be given to it in construing section 49. It was not claimed at the trial that defendant had failed to comply with any of the provisions of our statute necessary to authorize it to insure property in this state, or that Kennedy was not duly licensed under the Insurance Law to carry on his business as an insurance broker. The following authorities tend to support the above construction of section 49: *Romberg vs. Kouther*, 27 Misc. Rep. 227, 57 N. Y. Supp. 729; *United Firemen's Ins. Co. vs. Thomas*, 92 Fed. 127, 34 C. C. A. 240, 47 L. R. A. 450; *Wood vs. Firemen's Fire Ins. Co.*, 126 Mass. 316. In Michigan and Wisconsin statutes somewhat similar in form have been held as intended to make brokers in those states who place policies in foreign insurance companies agents in fact, for those companies with all the legal consequences of an actual agency. *Pollock vs. German Fire Ins. Co.*, 127 Mich. 460, 86 N. W. 1017; *Bliss vs. Potomac Fire Ins.*

Co., 134 Mich. 212, 95 N. W. 1083; Welch vs. Fire Ass'n, 120 Wis. 456, 98 N. W. 227. The statutes in those states differ somewhat from our own, but in so far as they are alike I think they should not be followed in the construction of our statute in view of its history as before stated.

There was proof of relations of a more or less intimate character between Kennedy, the broker, and Walsh, the local agent of the defendant. They occupied adjoining offices. Plaintiff did not ask to have left to the jury any question as to whether these relations were such as to constitute Kennedy and his assistant, Mooney, agents in fact for defendant under Walsh or his clerks, and so authorized to act for defendant within the doctrine of Arff vs. Star Fire Ins. Co., 125 N. Y. 57, 25 N. E. 1073, 10 L. R. A. 609, 21 Am. St. Rep. 721. We have, therefore, no occasion here to consider that question.

We think the trial court erred in instructing the jury, as matter of law, that Kennedy and Mooney were agents of defendant. If they were in fact brokers in the transaction, and not authorized to represent and act for defendant, then they did not become defendant's agents by virtue of section 49 of the Insurance Law, and any knowledge or notice received by them from plaintiff in the course of soliciting plaintiff to take out insurance, preparing her application, and negotiating for the policy is not to be imputed to defendant.

The judgment and order appealed from should be reversed, and a new trial ordered, with costs to the appellant to abide the event. All concur.

SUPREME COURT OF NEW YORK.
APPELLATE TERM, FIRST DEPARTMENT.

WHITLOCK ET AL.

vs.

GREENBERG ET AL.*

1. INSURANCE—ACT OF AGENT—RATIFICATION—EVIDENCE.
Evidence *held* to establish ratification by an insurance company of the act of its broker in employing an attorney to collect a premium.
(For other cases, see Insurance, Cent. Dig. § 124; Dec. Dig. § 94.)

2. INSURANCE—PREMIUMS—PAYMENT TO AGENT—RATIFICATION.

Payment to such attorney was payment to the company.

(For other cases, see Insurance, Cent. Dig. § 397; Dec. Dig. § 186[3].)

* Decision rendered, May 26, 1916. 159 N. Y. Supp. 184.

Appeal from Municipal Court, Borough of Manhattan, Ninth District. Action by Daniel Whitlock and another against Jacob Greenberg and another. From a judgment in Municipal Court for plaintiffs, defendants appeal. Reversed, and complaint dismissed.

Argued May term, 1916, before Guy, Bijur, and Cohalan, JJ.

Maurice Millimet, of New York City, for Appellants.
Joseph E. Lauber, of New York City, for Respondents.

GUY, J.

Defendants appeal from a judgment entered by direction of the court in favor of plaintiffs after a trial without a jury. Plaintiffs sue as assignees to recover a short-rate or pro rata premium under a policy of fire insurance issued by the Insurance Company of North America, plaintiffs' alleged assignor, to the defendants, and subsequently canceled.

The insurance was effected through one Hangley, a broker, who testified that it was the custom between himself and the Insurance Company of North America for the company to charge him with the amount of the premium and have him collect from the insured; that he was "the medium of collection." Hangley employed one Robinson, an attorney, to collect the claim, and defendants paid the claim in full to said attorney, who after deducting his charge of 25 per cent for collection, forwarded the amount to plaintiffs' assignor, the Insurance Company of North America, which refused to accept payment.

[1, 2] The plaintiff on the trial contended that Hangley had not been authorized to employ an attorney in collecting claims, and there was no direct proof of such an authorization. Hangley, however, testified that, after placing the claim in Robinson's hands, he sent Robinson to the insurance company's office in the same building, and Robinson there obtained the data to make up the claim. Another witness, who was formerly in the office of Attorney Robinson, testified that he waited upon one of the plaintiffs, who at the time were the legal representatives of the insurance company, told him that Robinson had collected the claim against defendants, and was told by said plaintiff that they would accept a check of Robinson for the amount of the premium less his charges for collection.

The evidence establishes ratification of the broker's act in employing Robinson to collect, and defendants' payment to Robinson must be deemed a payment to plaintiffs' assignor, the insurance company.

The judgment must therefore be reversed, with \$30 costs, and the complaint dismissed, with costs. All concur.

**BAILEY vs. FIRST NAT. FIRE INS. CO. OF WASHINGTON,
D. C. (No. 7085.)***

(Court of Appeals of Georgia.)

1. INSURANCE—NOTICE OF LOSS—WAIVER.

Under the allegations of the plaintiff's petition as amended, the plaintiff was not entitled to recover, and the court did not err in sustaining a general demurrer and dismissing the action.

- (a) The suit was upon a contract of fire insurance, and it appears from the petition that the plaintiff failed to give immediate written notice of the loss to the company, in accordance with the stipulation of the contract which provided that, "if fire occur the insured shall give immediate notice of any loss thereby in writing to this company." The contract further provided that no suit on the policy should be sustainable until after full compliance with this, among other requirements. Compliance with this stipulation was a condition precedent to the payment of the loss. *Southern Home Building & Loan Ass'n vs. Home Ins. Co.*, 94 Ga. 167, 21 S. E. 375, 27 L. R. A. 844, 47 Am. St. Rep. 147; *Graham vs. Niagara Fire Ins. Co.*, 106 Ga. 840, 32 S. E. 579.
- (b) The alleged waiver of the requirement was ineffective, because it was subject to the exception which provided that no officer, agent, or representative of the company should have power to waive or be deemed to have waived any provision or condition of the policy, unless such waiver be written upon or attached thereto. *Hutson vs. Prudential Ins. Co.*, 122 Ga. 847, 50 S. E. 1000; *Johnson vs. Aetna Ins. Co.*, 123 Ga. 404, 51 S. E. 339, 107 Am. St. Rep. 92.

(For other cases, see *Insurance*, Cent. Dig. §§ 952-954, 1521; Dec. Dig. § 376[1], 612[2].)

2. INSURANCE—PROOF OF LOSS—WAIVER.

It not appearing from the allegations of the petition that the person to whom an affidavit as to the loss by fire was delivered was an agent authorized to receive proof of loss in behalf of the defendant, it was not made to appear that the stipulation which required the insured to render a statement to the company as to the time and origin of the fire, etc., was complied with; and compliance with this stipulation was, in the absence of an extension of the time or a waiver in the manner prescribed in the policy, a condition precedent to recovery.

(For other cases, see *Insurance*, Cent. Dig. §§ 1603-1605; Dec. Dig. § 634[2].)

3. INSURANCE—NOTICE OF PROOFS OF LOSS—WAIVER.

While a failure on the part of the insured to furnish notice and proof of loss, induced by deception or gross neglect on the part of an insurer, may not prevent a recovery upon a contract of fire insurance, because in such a case the insurer would be estopped by his conduct to insist upon a forfeiture, still the alleged fact that the insurer refused payment at a particular time when (construing the allegations of the pleadings strictly) the conditions precedent to payment had not been complied with, would not, without more, estop the insurer from defending upon the ground that there had been a failure to furnish

* Decision rendered, May 31, 1916. 89 S. E. Rep. 80. Syllabus by the Court.

notice of the fire and proof of loss as required by the terms of the contract.

(For other cases, see Insurance, Cent. Dig. §§ 1382, 1383, 1389, 1390; Dec. Dig. § 558[1].)

Error from Superior Court, Fulton County; Geo. L. Bell, Judge.

Action by Corry Bailey, for use, etc., against the First National Fire Insurance Company of Washington, D. C. Judgment for defendant, and plaintiff brings error. Affirmed.

Powers & Leavitt, of Atlanta, for Plaintiff in Error.

Little, Powell, Smith & Goldstein, of Atlanta, for Defendant in Error.

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McAFEE vs. DIXIE FIRE INS. CO. (No. 6978.)*

(Court of Appeals of Georgia.)

INSURANCE—ACTIONS ON POLICIES—PLEADINGS.

There was no error in dismissing the petition, as it was subject to the demurrer interposed.

(For other cases, see Insurance, Cent. Dig. §§ 1593, 1596, 1598; Dec. Dig. § 634[1].)

Error from City Court of Macon; Robt. Hodges, Judge.

Action by J. C. McAfee against the Dixie Fire Insurance Company. Judgment for defendant, and plaintiff brings error. Affirmed.

Hardeman, Jones, Park & Johnston and Harry S. Strozier, all of Macon, for Plaintiff in Error.

King & Spalding and Daniel MacDougald, all of Atlanta, for Defendant in Error.

* Decision rendered, May 30, 1916. 89 S. E. Rep. 181. Syllabus by the Court.

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CITIZENS' INS. CO. vs. HEBERT, SECRETARY OF STATE.

(No. 21650.)*

(Supreme Court of Louisiana.)

1. INSURANCE—FOREIGN CORPORATIONS—RIGHT TO DO BUSINESS—“TAX”—STATUTE.

Act No. 295 of 1914, requiring foreign fire insurance companies to pay the state treasurer 1 per cent. of premiums received, to be turned over to the proper officers of the fire departments of cities, towns, and villages, under penalty of \$500 or revocation of their license to do business

* Decision rendered, Jan. 24, 1916. On rehearing, June 5, 1916. 71 So. Rep. 955. Syllabus by Editorial Staff.

in the state, does not levy a "tax," though it is a requisition by the sovereign authority of an amount of money to be contributed toward the public expenses, as it lacks the essential feature of a tax of being obligatory.

For other cases, see Insurance, Cent. Dig. §§ 16, 18-22; Dec. Dig. § 20.)
(For other definitions, see Words and Phrases, First and Second Series, Tax.)

8. INSURANCE—FOREIGN COMPANIES—RIGHT TO EXCLUDE.
The state has the right to exclude a foreign insurance company that has established a business in this state.

(For other cases, see Insurance, Cent. Dig. § 23; Dec. Dig. § 21.)

Appeal from Twenty-Second Judicial District Court, Parish of East Baton Rouge; H. F. Brunot, Judge.

Suit by the Citizens' Insurance Company against Alvin E. Hebert, Secretary of State. From a judgment for plaintiff, defendant appeals. Judgment set aside, injunction dissolved, and suit dismissed.

R. G. Pleasant, Atty Gen., and Harry Gamble, Asst. Atty. Gen., for Appellant.

J. Zach Spearing, of New Orleans (C. J. Doyle, of New York City, and Legier & Gleason, of New Orleans, of counsel), for Appellee.
Howe, Fenner, Spencer & Cocke, of New Orleans, amicus curiae.



REVIEW PRINTING CO. vs. HARTFORD FIRE INS. CO.

ET AL. (No. 19817[207].)*

(Supreme Court of Minnesota.)

INSURANCE—EXTENT OF RISK—PROPERTY COVERED—"FIXTURE."

Appellants issued their policies insuring certain property belonging to plaintiffs against loss or damage by fire. Plaintiffs conducted a printing office. The language of the policies covered "printing presses, type, furniture and fixtures, electric motors, imposing stands, and such other merchandise, furniture, and fixtures as are usually kept and used in a printing office." A fire in plaintiffs' printing office damaged a linotype machine kept and used in the office. Held, that the language of the policies covered the linotype machine.

(For other cases, see Insurance, Cent. Dig. §§ 342, 344; Dec. Dig. § 163 [3].)

(For other definitions, see Words and Phrases, First and Second Series, Fixture.)

Appeal from District Court, Swift County; G. E. Qvale, Judge.

Action by the Review Printing Company against the Hartford Fire Insurance Company and others. Pending action the Continental Insurance Company and certain of the defendants compromised with plaintiffs.

* Decision rendered, June 2, 1916. 158 S. W. Rep. 39. Syllabus by the Court.

From a judgment for plaintiffs, defendants Hartford Fire Insurance Company and another appeal. Affirmed.

Nathan H. Chase, of Minneapolis, for Appellants.
O'Brien, Young & Stone, of St. Paul, for Respondents.

**PATTERSON vs. AMERICAN INS. CO. OF NEWARK,
N. J. (No. 12016.)***
(Kansas City Court of Appeals. Missouri.)

**1. INSURANCE—ACTION ON POLICY—QUESTION FOR JURY—
APPLICATIONS FOR VACANCY PERMIT.**

In an action on a policy of fire insurance, plaintiff claiming that defendant did not act with reasonable promptness on receiving notice of vacancy, and did not cancel the policy, held, that whether plaintiff addressed and mailed to defendant a request for a vacancy permit three weeks before the fire was for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1735-1740, 1758-1760; Dec. Dig. § 668[4].)

Appeal from Circuit Court, Jackson County; D. E. Bird, Judge.
"Not to be officially published."

Action by Henry M. Patterson against the American Insurance Company of Newark, N. J. Verdict for defendant, and from the granting of a new trial, it appeals. Affirmed.

Ed. E. Yates, of Kansas City, for Appellant.
Fyke & Snider, of Kansas City, for Respondent.

* Decision rendered, May 22, 1916. 186 S. W. Rep. 552.

**GLOVER vs. LIVERPOOL & LONDON & GLOBE INS.
CO. (No. 11732.)***
(Kansas City Court of Appeals. Missouri.)

**1. INSURANCE—FIRE INSURANCE—VEXATIOUS REFUSAL TO
PAY LOSS—DAMAGES—STATUTE.**

Under Rev. St. 1909, § 7068, rendering an insurance company liable to damages for vexatiously refusing to pay any loss under a policy of fire insurance, where the insured's loss was found by the jury to be \$1,063.42, defendant was not liable to damages for refusing to pay \$1,800, the full amount of the policy.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

* Decision rendered, May 22, 1916. 186 S. W. Rep. 583.

2. INSURANCE—FIRE INSURANCE—VEXATIOUS REFUSAL TO PAY LOSS—DAMAGES.

A fire insurance company, after a loss, is not required, at its peril, to make tender of the actual loss, in the face of insured's demand for a greater sum, to avoid liability for damages for vexatious refusal to pay, and, if insured wishes to place the insurer in the wrong, he must demand and sue for nothing more than the actual loss.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

3. INSURANCE—FIRE INSURANCE—VEXATIOUS REFUSAL TO PAY LOSS—QUESTION FOR JURY—STATUTE.

Under Rev. St. 1909, § 7068, subjecting an insurance company to liability for damages for vexatious refusal to pay a fire loss, the whole question of vexatious refusal or delay is for the jury, to be determined from the evidence; the issue being the conduct of the insurer preceding filing of suit, and whether it refused to avail itself of a fair opportunity to discharge its obligation by paying the actual loss, or was deprived thereof by insured's conduct.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

4. INSURANCE—FIRE INSURANCE—VEXATIOUS REFUSAL TO PAY LOSS—STATUTES.

Under Rev. St. 1909, § 7068, subjecting an insurance company to liability for damages for vexatious refusal to pay any fire loss, a refusal or neglect of the insurer to pay what is due and payable is vexatious, and, if continued until suit is brought, entitles the insured to recover the penalty, though he sues for more than his actual loss.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

6. INSURANCE—FIRE INSURANCE—VEXATIOUS REFUSAL TO PAY LOSS—PLEADING.

In suit on a policy of fire insurance, the only fact required to be alleged to raise the issue of defendants' liability for the penalty, under Rev. St. 1909, § 7068, for vexatious refusal to pay the loss, is that it refused or failed to pay, and that the refusal or failure was vexatious, that plaintiff claims more than the actual loss being immaterial; the whole question of vexatious refusal being for the jury; and the real issue whether defendant before suit refused fair opportunity to discharge its liability.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

Appeal from Circuit Court, Buchanan County; Chas. H. Mayer, Judge.
Suit by Nicholas J. Glover against the Liverpool & London & Globe Insurance Company. From a judgment for plaintiff, defendant appeals. Judgment affirmed.

E. H. McVey and Park & Brown, all of Kansas City, and Du Val Smith, of St. Joseph, for Appellant.

Culver & Phillip, of St. Joseph, for Respondent.

COLLINGS CARRIAGE CO. *vs.* GERMAN-AMERICAN
INS. CO. ET AL. (No. 40/580.)*
(Court of Chancery of New Jersey.)

2. INSURANCE—AWARD—SUFFICIENCY.

Where pursuant to terms of contracts of insurance it was agreed that each party should appoint an appraiser, and that the two appraisers so appointed should appoint an umpire to whom they would submit their differences, and that an award in writing of any two should determine the amount of loss, the signature of the umpire is without vitality, unless and until the two appraisers have failed to agree.

(For other cases, see Insurance, Cent. Dig. § 1428; Dec. Dig. § 571.)

3. INSURANCE—AWARD—MISTAKE—EFFECT.

Where pursuant to the terms of insurance contracts two appraisers and an umpire were chosen and made an award as to the sound value of the property, which one of the appraisers signed without giving his consideration to or exercising his judgment on the subject, because he was told that the appraisal of the sound value of the property was a mere matter of form, the award was invalid, since, if, through fraud, accident, or mistake, an award does not embody the real judgment of the parties who return it, because there has been no consideration or attempt at consideration, it is not their award, nor a compliance with the requirements of the agreement of submission.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432; Dec. Dig. § 574[1].)

4. INSURANCE—AWARD—ERROR IN JUDGMENT.

The court has no concern with errors of judgment on the part of appraisers making an award.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432; Dec. Dig. § 574[1].)

Action by the Collings Carriage Company against the German-American Insurance Company and others. Final hearing on bill to set aside an award. Decree for complainant.

Joseph B. Tyler and Norman Grey, both of Camden, for Complainant.
James & Malcolm G. Buchanan, of Trenton, for Defendants.

* Decision rendered, April 22, 1916. 97 Atl. Rep. 726.

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DAVIS-KASER CO. *vs.* COLONIAL FIRE UNDER-WRITERS' INS. CO. (AGENCY) OF HARTFORD, CONN.
(No. 13208.)*
(Supreme Court of Washington.)

1. INSURANCE—ACTION—POLICY—VENUE.

Under Insurance Code (Laws 1911 p. 174) § 13½, providing that "any insurance company may be sued upon a policy of insurance in any

* Decision rendered, June 1, 1916. 157 Pac. Rep. 870.

county within this state where the cause of action arose," an action on a policy for loss of personal property must be brought in the county in which the policy was delivered and the property was located.

(For other cases, see Insurance, Cent. Dig. §§ 1536-1539; Dec. Dig. § 618.)

3. INSURANCE—CONTROL AND REGULATION—STATUTES— “CODE.”

The Insurance Code, supersedes and repeals all prior acts on the same subject, is a complete insurance code, and covers the entire subject of insurance, for the word “Code,” as used in the title, means a systematic and complete body of law upon the subject to which it relates.

(For other cases, see Insurance, Cent. Dig. § 4; Dec. Dig. § 4.)

(For other definitions, see Words and Phrases, First and Second Series, Code.)

Department 2. Appeal from Superior Court, Walla Walla County; Edward C. Mills, Judge.

Action by the Davis-Kaser Company against the Colonial Fire Underwriters' Insurance Company (Agency) of Hartford, Conn. From a judgment for defendant, plaintiff appeals. Affirmed.

Gose & Crowe, of Walla Walla, for Appellant.

McCarthy, Edge & Davis, of Spokane, for Respondent.



HOUSEMAN *vs.* HOME INS. CO. (No. 2893.)*

(Supreme Court of Appeals of West Virginia.)

3. INSURANCE—PROOFS OF LOSS—WAIVER—DENIAL OF LIABILITY.

Denial of liability on an insurance policy, based solely on an alleged want of unconditional ownership of the property destroyed, operates as a waiver of a provision thereof, requiring proofs of the quantum of loss as a prerequisite to an action on the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1391, 1392; Dec. Dig. § 559[1].)

4. INSURANCE—PROOFS OF LOSS—EXEMPTION OF INSURED.

The insanity of an insured at the time of the loss, continued thereafter during the limitation period prescribed by the policy for commencement of an action thereon, exempts compliance with the condition regarding proofs of loss.

(For other cases, see Insurance, Cent. Dig. § 1322; Dec. Dig. § 535.)

5. INSURANCE—ACTIONS ON POLICIES—BURDEN OF PROOF.

On the insurer against loss by fire rests the burden of proving, when averred in defense of an action on the policy, breach of the condition against misrepresentation or concealment by the insured of the true

* Decision rendered, April 18, 1916. Rehearing denied, May 19, 1916.
88 S. E. Rep. 1048. Syllabus by the Court.

ownership of the property damaged, or that the ownership thereof then was, or since has become, other than sole and unconditional. (For other cases, see Insurance, Cent. Dig. §§ 1650-1656; Dec. Dig. § 646[2].)

6. INSURANCE—FORFEITURE—BREACH OF CONDITION SUBSEQUENT—OWNERSHIP OF PROPERTY—“SOLE AND UNCONDITIONAL OWNERSHIP.”

Neither an option nor an invalid or conditional contract of sale of personal property by an insured, with reservation of title until payment of the purchase money, although possession is transferred to the vendee, will constitute a breach of the condition of the policy requiring “sole and unconditional ownership.”

(For other cases, see Insurance, Cent. Dig. § 605; Dec. Dig. § 282[2].) (For other definitions, see Words and Phrases, Second Series, Sole and Unconditional Ownership.)

Error to Circuit Court, Mercer County.

Action by W. H. Houseman, administrator, against the Home Insurance Company. Judgment for plaintiff, and defendant brings error. Affirmed.

Sexton & Roberts and Sanders, Crockett & Kee, all of Bluefield, for Plaintiff in Error.

Stokes & Sale, of Welch, for Defendant in Error.



CAMPBELL ET AL. vs. GERMANIA FIRE INS. CO OF NEW YORK.*

(Supreme Court of Wisconsin.)

6. INSURANCE—FIRE POLICY—ACTIONS—INSTRUCTION.

In an action on a fire policy, an instruction relating to the amount of loss which recalled to the jury that many articles of personality were totally destroyed or were damaged is not objectionable as suggesting that none of the personal property was saved, and if the insurer desired an explanatory instruction, it should have requested the same.

(For other cases, see Insurance, Cent. Dig. § 1780; Dec. Dig. § 669[12].)

11. INSURANCE—FIRE INSURANCE—ACTIONS—EVIDENCE.

In an action on a fire policy, where it appeared that part of the goods were destroyed by fire after they had been removed from the dwelling which burned, evidence held, to warrant a finding that the insured exercised reasonable care to protect the property as required by the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1711-1716; Dec. Dig. § 665[3].)

Appeal from a judgment of the Circuit Court for Pepin County; George Thompson, Circuit Judge.

* Decision rendered, May 23, 1916. 158 N. W. Rep. 63.

Judgment was rendered in favor of the plaintiff for the loss covered by the policy in conformity to the verdict of the jury.

Charles B. Obermeyer, of Chicago, Ill., and E. S. Pattison and C. A. Ingram, both of Durand, for Appellant.
W. E. Plummer, of Durand, for Respondents.

MARINE.**ST. PAUL FIRE & MARINE INS. CO. vs. BEACHAM.**

(No. 19.)*

(Court of Appeals of Maryland.)

1. INSURANCE—MARINE—EXTENT OF LIABILITY—“PARTICULAR AVERAGE.”

By the term “particular average” in marine insurance is meant a partial loss as distinguished from total loss or general average.

(For other cases, see Insurance, Cent. Dig. §§ 1230-1238; Dec. Dig. § 478.)

(For other definitions, see Words and Phrases, First and Second Series, Particular Average.)

2. INSURANCE—MARINE—EXTENT OF LIABILITY—“GENERAL AVERAGE.”

A “general average” loss in marine insurance is the amount lost to the owner of ship, cargo, freight, or other interest by any voluntary sacrifice made or extraordinary expense incurred for the benefit of all.

(For other cases, see Insurance, Cent. Dig. §§ 1248, 1249; Dec. Dig. § 477.)

(For other definitions, see Words and Phrases, First and Second Series, General Average.)

3. INSURANCE—MARINE INSURANCE—EXTENT OF LIABILITY—“CONSTRUCTIVE TOTAL LOSS.”

Under the American rule, there is constructive total loss, although not actually total, when the insured has the right to abandon the vessel, which right inures to him where the cost of saving and repairing the vessel exceeds one-half her value, in which case, by notice to underwriters, the owner may abandon his vessel and claim total loss.

(For other cases, see Insurance, Cent. Dig. §§ 1192-1227; Dec. Dig. § 469.)

(For other definitions, see Words and Phrases, First and Second Series, Constructive Total Loss.)

4. INSURANCE—MARINE INSURANCE—EXTENT OF LIABILITY—“CONSTRUCTIVE TOTAL LOSS.”

Under the English rule, the cost of salvage and repairs must exceed the full value of the vessel to constitute constructive loss.

(For other cases, see Insurance, Cent. Dig. §§ 1192-1227; Dec. Dig. § 469.)

5. INSURANCE—MARINE—“ACTUAL TOTAL LOSS.”

Under marine insurance, there is an actual total loss where the subject-matter is wholly destroyed, or lost to the assured, or where there remains nothing of value to be abandoned.

(For other cases, see Insurance, Cent. Dig. §§ 1188-1191, 1246; Dec. Dig. § 468.)

(For other definitions, see Words and Phrases, First Series, Actual Total Loss.)

* Decision rendered, April 26, 1916. 97 Atl. Rep. 708.

6. INSURANCE—MARINE INSURANCE—“FREE OF PARTICULAR AVERAGE.”

The expression “free of particular average” in a marine insurance policy is equivalent to “against total loss only.”

(For other cases, see Insurance, Cent. Dig. §§ 1230-1238; Dec. Dig. 478.)

(For other definitions, see Words and Phrases, First and Second Series, Particular Average.)

7. INSURANCE—MARINE INSURANCE—LIABILITY OF INSURER.

Under a marine insurance policy upon a vessel and not upon memorandum articles containing the clause “free of particular and general average,” the insurer is liable for constructive total loss.

(For other cases, see Insurance, Cent. Dig. §§ 1230-1238; Dec. Dig. 478.)

Appeal from Superior Court of Baltimore City.

“To be officially reported.”

Assumpsit by Harrison T. Beacham, trading as J. S. Beacham & Bros., against the St. Paul Fire & Marine Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Argued before Boyd, C. J., and Briscoe, Burke, Pattison, Urner, Stockbridge, and Constable, JJ.

Stuart S. Janney, of Baltimore (Harrington, Bigham & Englars, of New York City, and Ritchie, Janney & Griswold, of Baltimore, on the brief), for Appellant.

John H. Skeen, of Baltimore (Arthur D. Foster, of Baltimore, on the brief), for Appellee.

ACCIDENT AND HEALTH.**UNITED STATES CIRCUIT COURT OF APPEALS.
THIRD CIRCUIT.****PACIFIC MUT. LIFE INS. CO. OF CALIFORNIA****vs.****VOGEL. (No. 2079.)***

- 1. INSURANCE—RENEWAL RECEIPT—EFFECT OF DELIVERY.**
Where an accident insurance company, without a demand for payment of the premium, delivered a renewal premium receipt to the insured, which provided for extension of the insurance, such delivery does not, without acceptance by the insured or payment of the premium, extend the insurance, on the theory that the company is estopped to deny liability until cancellation of the receipt.

(For other cases, see Insurance, Cent. Dig. §§ 284-286; Dec. Dig. § 145[3].)

- 2. INSURANCE—ACCIDENT INSURANCE—POLICY—CONSTRUCTION.**

A renewal premium receipt, purporting to continue a policy in force, delivered pursuant to a custom which permits the payment of the premium within 60 days, fixes liability upon the insurer from the date of its acceptance by the insured, and not from the date of the payment of the premium.

(For other cases, see Insurance, Cent. Dig. §§ 284-286; Dec. Dig. §145[3].)

- 3. INSURANCE—ACCIDENT INSURANCE—RENEWAL PREMIUM RECEIPT—DELIVERY.**

An accident insurance company delivered to a policyholder a renewal premium receipt, duly countersigned, which purported to extend the policy for another year. At this time there had been no request by the policyholder for an extension of the insurance, nor was the premium paid for some time. It was the custom of the company to extend credit to policyholders in the matter of payment of premiums. *Held* that, while the mere delivery of the renewal premium receipt did not create a contractual obligation on the part of the company to maintain the policy in force, it was an offer to do so which the insured might accept by signifying intention within a reasonable time, or by payment within the period for which the credit was extended.

(For other cases, see Insurance, Cent. Dig. §§ 278-283, 287-291; Dec. Dig. § 145[1].)

- 5. INSURANCE—ACCIDENT INSURANCE—EXTENSION OF INSURANCE.**

In an action on an accident policy, which the insurer claimed had expired before the accident, the question whether, the renewal premium having been paid and accepted, the insurance was extended by the insured's acceptance of the renewal premium receipt, so that it cov-

* Decision rendered, May 3, 1916. Rehearing denied, June 17, 1916. 232 Fed. Rep. 337.

ered an accident occurring before payment and after the premium became due, held under the evidence for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1734, 1755; Dec. Dig. § 668[3].)

In error to the District Court of the United States for the Western District of Pennsylvania; W. H. Seward Thomson, Judge.

Action by Julia B. Vogel against the Pacific Mutual Life Insurance Company of California. There was a judgment for plaintiff, and defendant brings error. Affirmed.

Before Buffington, McPherson, and Woolley, Circuit Judges.

Benjamin J. Jarrett and Willis F. McCook, both of Pittsburgh, Pa., for Plaintiff in Error.

John E. Laughlin and F. C. McGirr, both of Pittsburgh, Pa., for Defendant in Error.

WOOLLEY, C. J.

This action was brought on a policy of accident insurance by the widow of the insured, who, in the event of her husband's death by accident, was the designated beneficiary. The defendant admitted the execution and delivery of the policy, but for defense maintained, that the policy had expired before the accident and had not been renewed; or if renewed, the failure of the insured to pay the renewal premium before the accident, relieved it of liability, and that a premium subsequently paid merely reinstated the policy as to injuries thereafter sustained. The jury rendered a verdict for the plaintiff; whereupon the defendant sued out this writ.

The errors assigned are directed mainly to the court's rulings upon the evidence, to its refusal to direct a verdict for the defendant and to the charge to the jury, so far as they were in opposition to the defendant's theory of the insurance transaction out of which the action arose. Error is also charged to the court in admitting certain testimony as part of the res gestæ and in refusing to direct a verdict for the defendant on the ground that the deceased came to his death by natural causes. With respect to the former, we discover no error, and with regard to the latter, we find that the evidence, while conflicting, was sufficient to submit to the jury and to support the verdict.

The real questions for review are, whether there was evidence upon which the jury, in rendering a verdict for the plaintiff, could find that a contract of insurance had been consummated between the insurance company and the insured by the delivery and acceptance of a renewal premium receipt, involving an extension of credit as to payment of premium, under which the company was liable for injuries sustained before payment was made, or whether the court erred in refusing to direct a verdict for the defendant on the ground that no contract of renewal had been consummated, that the original policy had expired before the accident, and that payment of premium after the accident reinstated the policy only

as to injuries thereafter sustained. The trial court submitted both these questions to the jury with appropriate instructions as to the verdict.

The Insurance Company issued to Joseph Vogel, Jr. (hereinafter referred to as the insured), a policy of accident insurance "for the term of twelve months from the sixth day of December, 1912." On December 1, 1913, a few days before the expiration of the term, the company issued and caused to be delivered to the insured a renewal premium receipt purporting to continue the policy in force for another term of twelve months. On March 2, 1914, being nearly three months after the date of the expiration of the original term, the insured met with an accident and sustained injuries from which he died. Between the date of the accident and the date of his death, the renewal premium was paid and accepted.

The plaintiff bases her right of recovery upon several grounds. The first is that the company charged the renewal premium to its agent pursuant to an established course of dealing, whereby it treated its agent as its debtor, and thereby waived payment of premium by the insured as a prerequisite to liability, invoking a familiar principle of law appearing in *Fidelity & Casualty Co. vs. Willey*, 80 Fed. 497, 25 C. C. A. 593 (C. C. A. 3d); *Lebanon Mutual Ins. Co. vs. Hoover*, 113 Pa. 591, 8 Atl. 163, 57 Am. Rep. 511; *Essington Enamel Co. vs. Granite State Fire Ins. Co.*, 45 Pa. Super. Ct. 550, 557, and cases cited. We are not satisfied that the evidence supports this contention.

[1] The next position of the plaintiff is, that the delivery of a renewal premium receipt, without a demand for prepayment of the premium and without circumstances from which its acceptance is to be inferred, creates a liability which the company is estopped to deny, raises the implication of an extension of credit and continues liability until the receipt is canceled. The logical deduction from this proposition is that the insurance company, by the mere delivery of a renewal premium receipt, waives the right not only to demand prepayment of premium, but to have the receipt accepted or rejected by the insured, which in legal effect amounts to an extension of credit without limit and a continuance of liability without consideration. This is hardly tenable.

[2] On the other hand, the defendant company relies upon a clause of the policy which provides, that:—

"If a *past-due premium* shall be accepted on this policy by the company, * * * such acceptance shall reinstate the policy in force as to disability resulting from accidental bodily injuries *thereafter sustained*."

It maintains that a renewal premium receipt purporting to continue a policy in force, delivered pursuant to a custom which permits the payment of the premium within sixty days, is effective only from the date of actual payment, and raises a liability of

indemnity only for accidents occurring thereafter, without regard to whether a contract of renewal had theretofore been consummated, embracing an extension of credit as to the payment of premium. We feel that this position is no more tenable than that of the plaintiff. It would be a violent construction of a contract of insurance renewal to hold, that the giving of credit for sixty days for the payment of the premium, postponed to the end of that period the time when the policy should be effective as a liability of the company, or in other words, that when a contract of insurance is made between the insurer and the insured, including an extension of credit to the latter for a given period within which to pay the premium, the payment of the premium becomes a condition precedent to an obligation on the part of the insurer, determined in point of time not by the date of the contract but by the date of the payment. What motive would the insured have in making such a contract? The credit given would be useless to him, for during the period of credit and until the premium was actually paid, he would not be insured. Connecticut General Life Insurance Co. vs. Mullen, 197 Fed. 299, 302, 118 C. C. A. 345, 43 L. R. A. (N. S.) 725 (C. C. A. 3rd). This position is likewise unsound. We must therefore inquire upon what theory the liability of the insurer and the right of the insured to recovery in such a transaction as this, are to be determined.

[3-5] It is clear, that, in the absence of statute upon the subject, the mere delivery of a renewal premium receipt does not create a contractual obligation on the part of an insurance company, though by its terms it purports to continue the policy in force. The renewal of a policy of insurance is in itself a contract of insurance, which, like any other contract, cannot be consummated without the mutual assent of the parties. Such a contract has its inception in a proposal, and its completion in the acceptance of the proposal. Until by some word or act of the insured, acceptance of the offer is expressly made, or from evidence of an established course of dealing between the parties, acceptance is necessarily inferred, no contract of renewal is created. When an offer to renew is accepted it becomes a contract of renewal upon the terms agreed upon, whatever they may be. The insurer may demand payment of premium upon the delivery of the receipt. Then there is no contract of insurance until the premium is paid. Or the insurer may waive its right to payment of premium before assuming liability, give a credit as to payment and enter into a contract complete in all respects, the subsequent payment of premium being a matter of performance and not a condition of the contract. Then liability exists from the consummation of the contract, though payment of the consideration for the liability be deferred to a future day.

Pursuing this line of thought, we are of the opinion that the delivery of the renewal premium receipt in this case was merely

an offer by the insurance company to the insured to enter into a new contract continuing for another year the insurance that was about to expire, *Richmond vs. Travelers' Ins. Co.*, 123 Tenn. 307, 130 S. W. 790, 30 L. R. A. (N. S.) 954, and that this offer raised in the insurance company no liability to indemnify the insured against accidents until it was accepted. Therefore, the pertinent inquiry is, as discerned by the learned trial judge and embodied in his submission of the case to the jury, whether there was evidence that the offer was accepted and the contract of renewal completed in terms which embraced an extension of credit for the payment of the premium beyond the date of the accident. *Pender vs. North State Ins. Co.*, 163 N. C. 98, 79 S. E. 293; *Mutual Reserve Life Ins. Co. vs. Heidel*, 161 Fed. 535, 88 C. C. A. 477 (C. C. A. 8th).

The circumstances of the transaction given in summary disclose that it had its inception in the renewal premium receipt delivered by the company to the insured, and received its first coloring from the language there employed. This receipt is in the following words:—

"Received of Joseph Vogel, Jr., \$70, *continuing in force* policy 1,115,218 from the 6th day of December, 1913, to the 6th day of December, 1914, at twelve o'clock noon, subject to all the conditions and agreements in the original policy. Not valid unless countersigned by the company's agent."

"Countersigned at Pittsburgh, Pa., the first day of December, 1913.

"Joseph A. Butler, General Agent."

The receipt is in the form used by other companies. *Richmond vs. Travelers' Ins. Co.*, *supra*. It was evidently used for a definite purpose, with an intended legal purport. While by its terms it was not valid unless countersigned by the company's agent, it was in this instance so signed and made valid within the company's meaning. Being thus deliberately framed and validated, it was delivered by the company, through its usual channels, to its general agent at Pittsburgh, by whom it was delivered to the firm of Horner and Ladley, insurance brokers and sub-agents to the general agent, by whom in turn it was delivered to the insured, without the intention on the part of anyone then to demand or to receive payment of the premium, although by its terms the company acknowledged payment.

It was testified that the delivery was made under a general custom of the company allowing an insured sixty days within which to pay the premium, and that from time to time and as exigencies arose, the time for payment of renewal premium had been extended even beyond that period. The extension of credit by general custom or in certain instances by special contract, was obviously done to induce hesitating patrons to renew their insurance. It appears that Vogel had been insured by the defendant

company or several years and was familiar with and had received the benefit of these practices. He was a soliciting agent of Horner and Ladley, the sub-agents to the general agent. He had received his renewal premium receipts and made premium payments to the company through that firm. As we have already stated, it does not satisfactorily appear that between Butler, the general agent, and Horner and Ladley, sub-agents, accounts were kept by which premiums were charged by the former against the latter. When Horner and Ladley placed insurance or when the company delivered renewal premium receipts to the customers of Horner and Ladley and the sixty day period of credit was about to expire or had expired, the practice of the general agency was to call upon the sub-agents, either by telephone or by the presentation of statements, asking for the payment of outstanding premiums. These demands generally preceded the date upon which the general agency was required to make settlement with the home office, being the last day of the month in which the credit period of sixty days expired. It appears in this case, that pursuant to that practice, the general agency, possibly at a date within the sixty day period but more probably at a date beyond it, followed up its offer to Vogel by calling upon Horner and Ladley for payment of Vogel's premium. This was sometime before the last day of February, 1914. Horner and Ladley communicated this call to Vogel, who immediately responded by saying that he would make payment in the early part of the next week, that is, sometime presumably during the first week in March. To this promise the company made no response, either by word or by cancellation of the outstanding receipt. It left the receipt in Vogel's hands, and permitted the matter to drag along until, on the second day of March, Vogel met with an accident. On the next day, formal notice of the accident was given both the sub-agency and the general agency. On the seventh day of March the premium was paid to the sub-agency by the son of the insured, and on the ninth day of March it was received by the general agency and transmitted to the company, which accepted and retained it. Five days later Vogel died.

So the question is whether the evidence discloses a consummated contract. That question can be determined only by ascertaining what the parties did and said. Their acts and utterances constitute the facts upon which the existence and the terms of a contract are to be determined. When evidence of these facts is in conflict or of a nature from which reasonable men may honestly draw different inferences, the existence of the contract and its terms are matters of fact to be determined by a jury. In this case, the trial court was called upon to decide whether the evidence was of a nature and in such conflict as to require submission to a jury, or disclosed a transaction susceptible of but one construction, to be determined by the court as a matter of law. In approaching

this question, what did the trial judge have before him? There was evidence of an unequivocal offer to continue in force a policy of insurance about to expire, a custom to extend credit for the payment of the premium for a given period, a practice to make further extensions to procure business, knowledge thereof and conduct thereunder by the insured in previous years, actual extension of credit in this instance beyond the customary period, a call for payment after the period of extension had been enlarged, a promise by the insured, perhaps in the nature of a counter-offer, to pay a few days later, no verbal response or act by the company either rejecting the counter-offer or withdrawing its original offer, an accident to the insured inferably within the period of the counter-proposition with the renewal premium receipt in his hands uncanceled, immediate and formal notice of the accident to the company, no response or inquiry on its part, subsequent payment of the premium and its acceptance and retention.

Is this testimony susceptible of but one construction, and with regard to that construction, is it of that certainty which is required when a court assumes to pass upon a fact as a matter of law? This testimony fairly raises the issue whether the payment of premium after the accident was in pursuance of a credit extended by a contract consummated before the accident, or was payment of a past-due premium upon a policy which had previously expired, by which the policy was reinstated only as to injuries thereafter sustained. Article 29. Upon this issue, we are of opinion, intelligent men may honestly differ. It they may, it is because the evidence presents different aspects. If in these aspects two theories are evolved and the evidence is sufficient to support either, then who but a jury can determine upon which theory the case must be decided? We concur with the trial court that the evidence was sufficient to support a verdict either for the plaintiff or for the defendant according as the jury found the payment had been made pursuant to a previously consummated contract, or for a past due premium. Upon this question the jury was sufficiently instructed, and its finding, as evidenced by its verdict, is binding.

The judgment below is affirmed.

McPHERSON, C. J.

I concur in the foregoing opinion, although with some hesitation on one point only. I am heartily in agreement with the legal principles that have been so clearly stated; the renewal receipt was a mere offer, or option, and could not become a contract until it had been accepted by Vogel. It seems to me therefore that the principal subject of inquiry should be the conduct of Vogel rather than the conduct of the company. The company had made its position clear by offering to renew, and its offer should certainly be taken in connection with the custom to allow the insured 60 days, or perhaps even longer, to make up his mind. But, as I read the evidence, the court should have instructed the jury that

Vogel never did make up his mind, and therefore that no contract of renewal was ever made. Upon this point, however, the other members of the court hold a different opinion, and believe that enough evidence was offered to go to the jury. I accept their view as more likely to be correct than my own, and I file this memorandum merely to emphasize the legal proposition upon which we are all agreed—that the renewal receipt was only an offer and had no binding force until Vogel accepted it.

SUPREME COURT OF WISCONSIN.

HARTWIG

vs.

AETNA LIFE INS. CO. OF HARTFORD, CONN.*

1. INSURANCE—DELIVERY AND ACCEPTANCE OF POLICY.

If a person applies for a policy, the application is accepted, and the policy is unconditionally deposited in the post office, addressed to the applicant, either by the company direct or through its agent, the applicant to pay the premium later, and nothing to the contrary expressed in the policy, a binding contract of insurance is made.

(For other cases, see Insurance, Cent. Dig. §§ 231-233; Dec. Dig. § 137[1].)

2. INSURANCE—PAYMENT OF PREMIUMS—CREDIT.

Credit may be given for the first premium of a policy of insurance, and if not expressly given, it may be shown to have been given by circumstances characterizing the transaction and the general course of business as conducted by the insurance company through its agent.

(For other cases, see Insurance, Cent. Dig. §§ 231-233, 1709; Dec. Dig. § 137[1], 665[2].)

3. INSURANCE—DELIVERY OF POLICY—CREDIT.

The unexplained delivery of a policy of insurance without payment of the premium is *prima facie* proof of an extension of credit.

(For other cases, see Insurance, Cent. Dig. § 1709; Dec. Dig. § 665[2].)

4. INSURANCE—CONTRACT—MEETING OF MINDS.

While it is essential that there shall be a meeting of minds in making an insurance contract, an express agreement upon all details not being necessary, acceptance by an insurance company of an application for a policy and an unconditional deposit in post office of such a policy, properly addressed, involves all requisites of a meeting of minds, since under such circumstances the minds of the parties are presumed to have met that the policy shall be as usual.

(For other cases, see Insurance, Cent. Dig. § 202; Dec. Dig. § 130[7].)

* Decision rendered, June 13, 1916. 158 N. W. Rep. 280.

5. INSURANCE—ACCIDENT INSURANCE—ACTION—QUESTION FOR JURY.

In an action by the beneficiary on a policy of accident insurance, the question whether the agent told the deceased when the application was taken that the policy would not go into effect until the premium was paid, testimony of the agent on this point, although not directly contradicted, being subject to doubt because of circumstances bearing on his credibility, was for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1734, 1755; Dec. Dig. § 668[3].)

6. INSURANCE—ACCIDENT INSURANCE—CREDIT—QUESTION FOR JURY.

Where the policy was mailed to the deceased, with a letter asking for prompt payment of the premium by an agent who had received the policy with instructions to collect and report, in advance of the payment of the premium, by registered letter calling for return of receipt, and directions to return if not called for within five days, the package remaining in the delivery post office three weeks after the expiration of the five days with knowledge of the agent, whether the credit was extended to the deceased *held* for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1734, 1755; Dec. Dig. § 668[3].)

7. INSURANCE—ACCIDENT INSURANCE—EVIDENCE—ADMISSIONS.

Evidence of previous dealings with the deceased and others and the general manner of doing business through the agent was admissible as circumstantially explaining the transmission of the policy in advance of payment.

(For other cases, see Insurance, Cent. Dig. § 1674; Dec. Dig. § 651[2].)

8. INSURANCE—ACCIDENT INSURANCE—ACCEPTANCE OF POLICY—QUESTION FOR JURY.

Where deceased did not call for the policy mailed to him, although notified several times to do so by the delivery post office, the deceased having requested retention of the letter, promising to call for it, whether he intended not to accept the policy or whether its delay was for the purpose of postponing payment *held* for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1734, 1755; Dec. Dig. § 668[3].)

Appeal from a judgment of the Circuit Court for Ozaukee County; M. L. Lueck, Circuit Judge. Affirmed.

Action by the beneficiary in an accident insurance policy to recover thereon.

The claim of plaintiff was that defendant, prior to September 12, 1914, issued to Max H. Hartwig, one of its accident insurance policies, in which she, his wife, was named as beneficiary, insuring him against accidental death in the sum of \$5,000.00, the insured to pay the premium therefor in the customary time; that the policy was in full force on such date when the assured came to his death from a cause within the risks insured against, and that, in due course, all conditions precedent to her right to commence and maintain an action to recover on the policy were performed.

Defendant claimed, among other things, that the policy sued on was not issued on credit; that August 14, 1914, the deceased made application for the policy through the company's agent, A. M. Wagner; that, in due

course, such policy was issued and sent to said agent for "collection and report"; that it was not to go into effect until acceptance thereof by the assured and payment of the premium; that the premium was not paid, nor the policy accepted; but on the contrary the assured neglected and refused to pay the premium or to accept the policy and that it was not in force at the time he was injured resulting in his death.

The case turned on whether the policy was in force on the 12th day of September, 1914. It was the third policy of the kind issued by defendant to Mr. Hartwig, on applications made through the agent who took the last one. The first was issued July 23, 1908, and sent to the assured July 26, thereafter, without payment of the premium. He paid part thereof August 24, 1908, and the balance September 24, thereafter, as the result of some urging to meet his obligation. The second policy was issued pursuant to an application dated April 14, 1910. It was sent to the local agent at the City of Port Washington, Wisconsin, with directions to deliver on payment of the premium. The assured did not make the payment and the policy was returned. The last policy was sent to the assured by registered letter August 17, 1914. It was transmitted by agent Wagner, who had received it with directions to "collect and report." It was so sent as to require a return receipt with a five day limit of delay at the delivery post office. The letter accompanying the policy asked for prompt payment of the premium so remittance to the company could be made without delay. The letter reached the delivery office at 9:30 A. M. August 18, 1914. Hartwig was duly notified on that day by the post master and notified a second time August 20, thereafter. Later he was notified several times by telephone of the presence of the letter at the post office awaiting his application therefor. It was in the office September 12, 1914, when he came to his death. The postal clerk was permitted to testify that in one of the telephone conversations which occurred some days before his death, he requested retention of the letter, promising to call for it. The deceased was a physician and was very busy attending to calls, during office hours, all the time during which he neglected to take the letter from the post office. No authority was expressly given by plaintiff, or in its behalf, to hold the letter beyond the five day limit. Hartwig was requested by a letter dated September 10, 1914, to send in payment of the premium. After his death the agent ordered the policy back. It was returned accordingly and sent to plaintiff. Wagner testified that, when the application was made, he informed the assured that the policy would go into effect as soon as the premium was paid. That was under objection that it was inadmissible under section 4069, Stats., and because whatever was said became merged in the written application. The policy contained a provision to the effect that in case of default in paying any premium, subsequent to acceptance of the same would operate to revive the policy only as to any loss happening thereafter.

Upon evidence proving or tending to prove all the circumstances above indicated, and other evidence under objection, of statements made by the accused, respecting the policy, to his son Earl, his daughter Mildred, the local agent, Mr. Adams, the post master and his clerk, indicating that, up to the time of his death he intended to call at the post office for the letter, and evidence, under objection, regarding payment of premiums by other applicants for insurance as well as the manner the assured paid for the first policy, the court submitted the cause to the jury. They found, (1) that the assured and the agent did not agree that the policy should not take effect until the premium was paid; (2) that it was mutually understood between the assured and the agent that the latter need not pay for the policy until he received it; (3) that the failure by the assured to take the policy from the post office was not due to a purpose not to accept; and (4) that such failure was not due to an intention to postpone the time of the premium.

Upon such verdict judgment was granted to the plaintiff.

Collins & Collins, of Sheboygan (Daniel F. Flannery, of Chicago, Ill., of counsel), for Appellant.

William F. Schanen, of Port Washington (James D. Shaw, of Milwaukee, of counsel), for Respondent.

MARSHALL, J.

A few well settled principles of law govern this case, if the findings are sustained by the evidence.

[1] If a person applies to an insurance company for a policy of insurance, the application is accepted, and policy is unconditionally deposited in the post office, addressed to the applicant, either by the company direct or through its agent, he, later, to pay the premium therefor, and there is nothing to the contrary, expressed in the policy, a binding contract of insurance is thereby made. Richards on Insurance (3d Ed.) p. 99, note; Armstrong vs. Mutual Life Insurance Co. of New York, 121 Iowa, 362, 96 N. W. 954; Triple Link M. I. Ass'n vs. Williams, 121 Ala. 131, 147, 26 South. 19, 17 Am. St. Rep. 34; Commonwealth Mutual Fire Insurance Company vs. William Knabe & Co., etc., 171 Mass. 265, 50 N. E. 516; Hartford S. B. & Ins. Co. vs. Lasher Stocking Co., 66 Vt. 439, 29 Atl. 629, 44 Am. St. Rep. 859; Bailey vs. Hope Insurance Co., 56 Me. 474; 1 Joyce on Insurance, § 62.

[2] Credit may be given for the first premium and, if not expressly given, it may be shown to have been given by circumstances characterizing the transaction and the general course of business as conducted by the insurance company through its agent. Tomsecek vs. Travelers' Ins. Co., 113 Wis. 114, 88 N. W. 1013, 57 L. R. A. 455, 90 Am. St. Rep. 846; 1 Joyce on Insurance, §§ 75 to 84.

[3] The unexplained delivery of a policy without payment of the premium is *prima facie* proof of an extension of credit. 1 Joyce on Insurance, § 85. In Washoe Tool Mfg. Co. vs. Hibernia Fire Ins. Co., 66 N. Y. 613, the policy provided that the company would not be liable unless the premium was actually paid to it. The policy was delivered without requiring payment. Payment was, thereafter, several times unsuccessfully demanded. The policy was not canceled nor was the holder notified that it would be void unless payment was made. The court held that the jury was justified in finding that the waiver of payment continued up to the loss and the company was liable. In Tomsecek et al. etc., vs. Travelers' Insurance Company this court reviewed many cases on the subject, holding that a general agent of an insurance company may waive the time of payment of the first premium, notwithstanding a provision in the policy that it will not take effect in advance of payment. The policy here did not contain any such provision. The adjudications cited by counsel for appellant, and quotations therefrom, which dealt with policies characterized by such a provision, are beside this case, and need not be referred to.

[4] It is contended that, notwithstanding the verdict, there

was no meeting of minds on the precise nature of the contract. While it is true that in making an insurance contract, the same as any other, it is essential that there shall be a meeting of minds; that does not mean that there must be an express agreement upon all details. The acceptance by an insurance company of an application for one of its policies and an unconditional deposit in the post office of such a policy, properly addressed; involves all requisites of a meeting of minds. Commonwealth Mutual Insurance Co. vs. Knabe & Co., *supra*; Richards on Insurance (3d Ed.) § 79. That applies particularly to the rate of insurance. Under such circumstances, the minds of the parties are presumed to have met that the policy shall be as usual, and the rate the usual one, or a reasonable rate, or the same as before where the applicant has previously had a similar policy. So there is no question but what there was the requisite meeting of minds here, unless the contrary appears from some circumstances yet to be considered.

[5] It is contended that this case does not fall within the rule we have discussed because the deceased was told by the agent, when the application was taken, that the policy would not go into effect until the premium was paid. The only evidence on that was given by the agent, under objection. Waiving the question, of whether the evidence was proper, under the rule prohibiting contradiction or variation of a written contract by parol, and whether it was proper under section 4069, Stats., it was a jury question as to whether any such circumstance occurred as the agent testified to, and the finding, in respondent's favor, settled the matter. True, there was no direct contradiction of the agent's testimony, but there were circumstances bearing on its credibility which appear in the record and there were, probably, others which do not appear. The trial judge had the advantage of seeing the witness and hearing his testimony given, and came to the conclusion from the whole situation that its credibility was so involved, that the jury should be permitted to pass upon it. The result is not clearly wrong, if wrong at all, as to warrant disturbing it.

It is further contended that there was no efficient delivery by mail to close a contract of insurance because the policy was sent to the agent coupled with the condition that he should "collect and report." The instruction is not free from ambiguity. There is a strong probability that it did not differ from the usual course where the policy is sent and charged to the agent with the expectation that he will report collection on it with other collections, make his remittance, and obtain his credit. True, there is no very definite evidence as to the customary course of business, but there was enough to raise the question in respect thereto. On the whole, what was meant by the instructions to "collect and report," in view of the fact that the policy was, promptly, upon its receipt by the agent, transmitted to the deceased without pre-

payment of the premium, is fairly involved in whether credit was extended, in respect to which the jury found in respondent's favor.

It was further suggested that the policy was transmitted conditionally, because of its having been sent by registered letter, demanding a receipt, and of the direction on the package to return if not called for within five days. Whether those circumstances evidenced a condition of the deceased having the policy, or merely a precaution against its going astray and to secure evidence of its having reached his hand, is so involved as to fairly fall within the subject of extension of credit. The fact that the package remained at the delivery office for some three weeks after expiration of the five days, to the knowledge of the agent, and he acquiesced therein, by not ordering it back, and by writing to the assured to send on the premium, which appears by the evidence without controversy, rather indicates that the five day return feature was not a condition, or, if it were, the condition was waived.

[6, 7] It is further contended that there was no evidence warranting the finding that there was an extension of credit to the deceased which relieved him from the obligation to pay the premium until he received the policy into his possession. What we have already said sufficiently answers that in favor of respondent. The fact that the policy was transmitted in advance of the premium being paid, was sufficient, of itself, to warrant submitting the matter to the jury. The letter accompanying it, asking for prompt payment, certainly suggests that deceased was trusted to pay after receiving the policy. There were many other circumstances, including the history of previous dealing with the deceased and others, and the general manner of doing business through the agent. We will not take time to go into all the details. The evidence was all competent in our judgment, as circumstantially explaining the transmission of the policy in advance of payment.

[8, 9] There was evidence to carry the question to the jury of whether the deceased intended not to accept the policy and whether his delay was for the purpose of postponing payment. In this connection we note the contention that the evidence of what the deceased said to members of his family and to the clerk at the post office in respect to the policy, during the period of delay, was incompetent. We think his state of mind in respect to the matter, as characterized by the circumstances referred to, was very material and that such circumstances were competent evidence as matter of *res gestæ*.

It is further contended that the policy did not become operative because the premium was not paid and the assured did not become obligated to pay it. That payment of the premium was not necessarily a condition of the policy becoming operative, we have seen. If it was sent to the assured, trusting him to pay after receipt thereof, and he did not repudiate his offer to take it, as the jury

found, then, of course, he became obligated to pay therefor. Treating the findings of the jury as verities, all elements of a complete contract existed and persisted to the end.

The policy contained a provision to the effect that, in case of default in payment of any premium on the policy, it would not be in force during the period of default so as to cover any loss sustained during such period. It is contended that such provision is fatal to the judgment, as the assured was in default when he was injured. Whether such provision included the first premium on such a policy is not clear. But let that be as it may, as the jury found credit was extended to the assured, he was never in default.

We have now treated in general, or particular, all points raised by counsel for appellant which seem to merit it without discovering any reason for reversing the judgment. True, the conduct of the assured, in neglecting for a long time to take his policy from the office, was not very satisfactorily explained; but there was enough evidence on the subject to carry the question to the jury as to whether he intended to, or did, reject the policy. That respondent did not consider it rejected is quite strongly indicated by the fact that the agent acquiesced in its not being returned, did not cancel it, or notify the assured that it would not be treated as operative, and, with knowledge of the delay, requested assured to remit the premiums. That, in connection with all the other circumstances to which we have referred, are quite as indicative of a waiver of payment, continuing up to the time of the accident which resulted in the death of assured, as existed in *Washoe Tool Mfg. Co. vs. Hibernia Fire Insurance Co.*, 66 N. Y. 613, referred to before in this opinion.

The unpaid premium should have been credited on the policy indebtedness and judgment entered only for the remainder. That, doubtless, would have been done had the attention of the trial court been called to the matter. We have concluded that the application should be made now; but, under the circumstances, without effect as to costs. It will be a substantial correction of the judgment, and all that is due, considering the delay in raising the question, to allow the unpaid premium of \$30.00 as a deduction from the judgment, not taking account of interest thereon from the date of the policy to the date of the judgment.

The judgment is modified by reducing it \$30.00 as of the date it was rendered and affirmed, as so modified, full costs in this court to go to respondent.

**PORTRER vs. GENERAL ACC. FIRE & LIFE ASSUR.
CORP., LIMITED. (Civ. 1692.)***

(District Court of Appeal, Second District, California.)

1. INSURANCE—AGENTS—POWERS OF.

One having authority to take applications, receive and receipt for premiums, and deliver policies after countersigning them has no power to bind the company by a contract of insurance in any other way than by delivery of a policy issued by the company.

(For other cases, see Insurance, Cent. Dig. §§ 219, 225; Dec. Dig. § 136[1].)

2. INSURANCE—AGENTS—“GENERAL AGENT.”

A “general agent” is one having all the powers of his principal as to the business in which he is engaged, but an agent having such powers within a specified locality authorized to appoint local agents, is deemed a general agent of an insurer, though his power is not co-extensive with the insurer’s business.

(For other cases, see Insurance, Cent. Dig. §§ 117, 118; Dec. Dig. § 88.)

(For other definitions, see Words and Phrases, First and Second Series, General Agency or Agent.)

3. INSURANCE—AUTHORITY OF AGENT—LIMITATION.

An insurance company may limit the powers of its agent, and where the limitation is incorporated in the policy, an applicant by accepting the policy becomes charged with such limitation.

(For other cases, see Insurance, Cent. Dig. §§ 222-224, 229, 230; Dec. Dig. § 136[5].)

4. INSURANCE—POLICIES—WAIVER OF CONDITIONS.

Ordinarily an insurance agent cannot effect a waiver in the face of a limitation in the policy, denying his power to waive warranties or conditions, unless he is authorized to conclude contracts of insurance without referring them to the insurer, and to issue and deliver policies.

(For other cases, see Insurance, Dec. Dig. § 90.)

5. INSURANCE—APPLICATION—STATEMENTS.

Where an applicant for insurance signs an application certifying to the truth of statements therein contained material to the risk, those statements become his solemn representations, though they be filled out by the insurer’s agent.

(For other cases, see Insurance, Cent. Dig. §§ 1011-1015; Dec. Dig. § 379[4].)

6. INSURANCE—APPLICATION—REPRESENTATIONS.

Where an applicant for an insurance signs an application, which is made a part of the policy, he is bound by its terms, and cannot question representations therein appearing on the ground that he did not read the policy.

(For other cases, see Insurance, Cent. Dig. § 540; Dec. Dig. § 256[2].)

7. INSURANCE—ACCIDENT AND LIFE INSURANCE—REPRESENTATION.

Where an insurer required an applicant for a health and accident policy

* Decision rendered, March 24, 1916. 157 Pac. Rep. 825.

to state whether he had suffered from diseases of his eyes, answers to such questions are material.

(For other cases, see Insurance, Cent. Dig. § 687; Dec. Dig. § 291[4].)

8. INSURANCE—HEALTH AND ACCIDENT INSURANCE—REPRESENTATIONS.

Civ. Code, § 2607, declares that a statement in a policy relating to the person or thing insured, or to the risk, is an express warranty thereof, while section 2612 provides that a breach of a warranty where it is broken in its inception prevents the policy from attaching. An applicant for a health and accident policy was questioned as to any diseases of the eyes. The answers were written by the insurer's agent and were false. The policy was not issued by such agent but by the insurer's general agent on the answers contained in the application which was made a part of the policy. The policy was duly accepted by the insured. *Held*, that he was bound by the representations contained in his application, and therefore, the representations being false, no recovery could be had under the policy.

(For other cases, see Insurance, Dec. Dig. 291[2].)

Appeal from Superior Court, Los Angeles County; Grant Jackson, Judge.

Action by R. C. Porter against the General Accident, Fire & Life Assurance Corporation, Limited. From a judgment for plaintiff, defendant appeals. Reversed.

Herbert W. Kidd and Perry F. Backus, both of Los Angeles, for Appellant.

T. A. Williams, of Los Angeles, for Respondent.



HICKEY vs. MINISTERS' CASUALTY UNION.

(No. 19822[155].)*

(Supreme Court of Minnesota.)

1. INSURANCE—ACTIONS ON POLICIES—EVIDENCE.

Action by the beneficiary in an accident insurance policy to recover thereon. The policy provided for specified sums to be paid for different bodily injuries, and for the payment of the amount of the policy "if death shall result from injuries alone, and not proximately from some disease induced or aggravated by said injuries, and within three calendar months after the date on which the injuries were received." It is held: The evidence warranted the jury in finding that the death of the insured resulted from his injuries alone, and not proximately from a disease induced or aggravated by such injuries.

(For other cases, see Insurance, Cent. Dig. §§ 1719, 1722; Dec. Dig. § 665[5].)

* Decision rendered, June 2, 1916. 158 N. W. Rep. 45. Syllabus by the Court.

2. INSURANCE—LIABILITY OF INSURER—“DISEASE”—TRAUMATIC PERITONITIS.

As a result of the accident the insured suffered from traumatic peritonitis, or an inflammation of the peritoneum caused by a blow on the abdomen. *Held*, that his death was not proximately caused by a disease, within the meaning of the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1178, 1186; Dec. Dig. § 466.)

(For other definitions, see Words and Phrases, First and Second Series, Disease.)

4. INSURANCE—ACTIONS ON POLICIES—EVIDENCE.

The evidence warranted the jury in finding that the injuries from which the insured died were received in an accident.

(For other cases, see Insurance, Cent. Dig. §§ 1719, 1722; Dec. Dig. § 665[5].)

Appeal from District Court, Hennepin County; William E. Hale, Judge.

Action by Margaret Hickey, also known as Mrs. C. Hickey, against the Ministers' Casualty Union. From an order denying a new trial, defendant appeals. Affirmed.

Arthur Markve and Merrill C. Tiffet, both of Minneapolis, for Appellant.

Boyce & Davidson, of Amarillo, Tex., and James E. Dorsey and Lancaster, Simpson & Purdy, all of Minneapolis, for Respondent.

**GILLIS vs. DULUTH CASUALTY ASS'N.**

(No. 19749[140].)*

(Supreme Court of Minnesota.)

**1. INSURANCE—ACTIONS ON POLICY—QUESTIONS FOR JURY
—“OBVIOUS RISK OF INJURY.”**

A policy of accident insurance exempted the insurer from liability in case the accident resulted from “unnecessary exposure to obvious risk of injury.” It is *held* that the insured, a passenger on a railroad train, did not as a matter of law expose himself to obvious risk of injury, within the meaning of the policy, by going upon the platform of a moving car preparatory to getting off at a station; and the trial court properly submitted the question of unnecessary exposure to the jury.

(For other cases, see Insurance, Cent. Dig. § 1181; Dec. Dig. § 461[2].)

2. INSURANCE—EXTENT OF RISK—“PASSENGER.”

A policy of accident insurance provided for double indemnity when the injury was sustained “while riding as a passenger on any railway passenger car.” It is *held* that the insured when on the platform of a car preparatory to getting off, in the way provided by the carrier,

* Decision rendered, June 9, 1916. 158 N. W. Rep. 252. Syllabus by the Court.

or in the act of doing so, was within the meaning of the policy riding as a passenger on a railway passenger car.

(For other cases, see Insurance, Cent. Dig. §§ 1312, 1313; Dec. Dig. § 527.)

(For other definitions, see Words and Phrases, First and Second Series, Passenger.)

Appeal from District Court, St. Louis County; J. D. Ensign, Judge.

Action by J. A. Gillis against the Duluth Casualty Association. From an order denying an alternative motion for judgment or for a new trial, defendant appeals. Affirmed.

Wharton & Wharton, of Duluth, for Appellant.

Dietrich & Dietrich, of Superior, Wis., and Jno. Jenswold, Jr., of Duluth, for Respondent.

CASUALTY, SURETY AND MISCELLANEOUS.**UNITED STATES DISTRICT COURT.**

D. OREGON.

BROWN & McCABE, STEVEDORES, INC.,

vs.

LONDON GUARANTEE & ACCIDENT CO.*

INSURANCE—EMPLOYERS' LIABILITY INSURANCE—LIABILITY OF INSURER.

Where an employers' liability insurer, recognizing its liability and having ascertained that an injured employee would settle for less than the amount of the policy, refused to pay the claim, unless the policyholder would bear half the loss, the insurer, having attempted to coerce the policyholder, is liable, the employee having recovered a judgment considerably in excess of the amount of the policy, for such excess.

(For other cases, see *Insurance*, Dec. Dig. 512.)

At Law. Action by Brown & McCabe, Stevedores, Incorporated, against the London Guarantee & Accident Company. On demurrer. Demurrer overruled.

Ralph E. Moody, A. Walter Wolf, and John F. Reilly, all of Portland, Or., for Plaintiff.
Griffith, Leiter & Allen, of Portland, Or., for Defendant.

BEAN, D. J.

The case is based on a liability policy issued in November, 1910, by which the defendant company agreed to indemnify the plaintiff against liability for personal injuries sustained by an employee. The policy provided that immediately after an accident or loss the company should be notified thereof, and if suit or action were commenced it should be advised of same, it to defend such suit or action at its own cost and expense, or settle same as it might deem advisable. The policy also provided that the assured might settle claims at its own expense, giving immediate notice thereof in writing to the insurance company, or at the expense of the company if authorized to do so in writing, and that no suit should be brought against the company for any loss after 90 days from the payment thereof.

The plaintiff alleges that one of its employees was injured; that the defendant insurance company was immediately notified thereof, investigated the claim, ascertained that there was a liability, and that the injured party would settle for \$3,000, \$2,000 less

* Decision rendered, October 11, 1915. 232 Fed. Rep. 298.

than the face of the policy. It thereupon notified the plaintiff of the offer and demanded that it pay one-half of the amount, or \$1,500, stating that, in case the plaintiff would not do so, it would permit the pending action to proceed to trial, and it would necessarily result in a judgment in excess of the face of the policy, so that the assured would ultimately be compelled to pay more than the \$1,500. The plaintiff refused to accede to this demand, the case was tried, and the employee recovered a judgment for \$12,000. The insurance company thereupon paid \$5,000, the face of its policy, and costs, and refuses to pay any more. This action is brought to recover the balance.

Now, I understand from counsel, confirmed by my own investigations, there are no authorities directly in point. It has been held that, under a policy like the one in question, the insurance company has a right to settle with an injured employee or not, as it deems advisable, and if it neglects or refuses to do so, and litigates the matter in good faith, and judgment is recovered for more than the face of the policy, it is not liable for the excess. But that is not this case. This is a case where, according to the allegations of the complaint, the insurance company attempted to hold up the assured and make it pay \$1,500, or one-half the loss, and, because it would not do so, suffered the action to proceed to judgment for more than double the face of the policy.

I conclude that under these circumstances the plaintiff should recover, and the demurrer in this case will be overruled.

SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FIRST DEPARTMENT.

McALEENAN

vs.

MASSACHUSETTS BONDING & INS. CO.*

1. INSURANCE—OFFER OF SETTLEMENT—PAYMENT.

Where the holder of a policy of automobile accident insurance indemnifying him to the extent of \$5,000 against loss by reason of an accident resulting in injuries or death to any person, after such an accident, pending suit by decedent's administratrix, defended by the insurer, learned the willingness of plaintiff to accept \$3,750, in full settlement of any damage that might be recovered in excess of \$5,000, but assured did not pay such sum to the administratrix, the insurance company was not liable for damages occasioned the assured by an

Decision rendered, June 2, 1916. 159 N. Y. Supp. 401.

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excess judgment on account of the insurer's refusal to accede to the proposed compromise.

(For other cases, see *Insurance*, Cent. Dig. § 1298; Dec. Dig. § 514.)

2. INSURANCE—ACCIDENT INSURANCE—CONSTRUCTION OF POLICY.

A policy of automobile accident insurance, merely providing that insured might not incur expenses or settle a claim, "except at his own cost," did not forbid payment by the insured to decedent's administratrix, pending suit, of \$3,750 which she offered to accept in settlement of any damages she might recover in excess of \$5,000, where such payment would not increase the insurer's liability or enhance its difficulties in defending the action.

McLaughlin and Dowling, JJ., dissenting.

Appeal from Special Term, New York County.

Action by Joseph A. McAleenan against the Massachusetts Bonding & Insurance Company. From an order granting a motion for judgment on the pleadings, defendant appeals. Order, in so far as it grants plaintiff judgment on his first cause of action, reversed, and defendant's motion for judgment in its favor granted, with leave to plaintiff to serve an amended complaint, and, in so far as it grants plaintiff judgment on his second cause of action, affirmed, with leave to defendant to withdraw its demurrer and answer.

Argued before Clarke, P. J., and McLaughlin, Laughlin, Scott, and Dowling, JJ.

Clayton J. Heermance, of New York City, for Appellant.
Herbert C. Smyth, of New York City, for Respondent.

McLAUGHLIN, J.

The complaint contains two causes of action. In the first it is alleged that the defendant issued to the plaintiff a policy of automobile insurance indemnifying him to the extent of \$5,000 against loss by reason of an accident resulting in injuries or death to any one person. The policy provided, among other things, that if an accident occurred, and action was brought against the assured to enforce the claim on account thereof, he would forward to the defendants the summons or other process served, and it would at its own cost and expense, and subject to the limitations contained in clause K of the policy, defend or, at its option, settle such action in the name and on behalf of the assured; that clause K provided, " * * * The assured shall not voluntarily assume any liability, nor shall the assured, without the written consent of the company previously given, incur any expense, or settle any claim, except at his own cost, or interfere in any negotiation for settlement, or in any legal proceeding;" that during the life of the policy an accident occurred, which resulted in the death of one Cimino; that his administratrix subsequently brought an action to recover the damages alleged to have been sustained by reason thereof; that the assured duly notified the defendant of the commencement of such action and delivered to it the summons and

complaint; that it thereupon undertook to defend the action for the plaintiff under the terms and conditions of the policy; that after issue was joined, at the request of the defendant, the assured procured the services of an attorney to be associated with the attorney of the insurance company at the trial; that during the progress of the trial the counsel for the plaintiff in that action made an offer to the assured to settle the same on payment of \$7,500, which offer the assured immediately communicated to the insurance company, at the same time signifying his willingness to settle at that sum, and if the settlement be had to pay one-half thereof, or \$3,750, provided the insurance company would pay the other half; that the insurance company refused to permit the plaintiff to settle the action, and the assured thereupon notified it he would hold the company responsible for any sum he might be called upon to pay by reason of such refusal; that, thereafter, and while the trial was still in progress, the plaintiff in that action offered to accept from the assured \$3,750 in full settlement and satisfaction of any damage that might be recovered in excess of 5,000, that the trial would be continued, and, in case a verdict were rendered in excess of \$5,000 that the same might be reduced to that sum, in consideration of such payment; that this offer was immediately communicated to the insurance company, and the assured at the same time stated to it his willingness to accept such proposition of settlement and pay the plaintiff in that action the sum of \$3,750 in consideration of her agreement to reduce any verdict that might be recovered to the sum of \$5,000; that the insurance company declined to permit such settlement, and stated to the assured, if he made the same, it would immediately deny all liability to him under the policy, on the ground that such settlement would be in violation of its terms and conditions; that the plaintiff protested against such refusal, and notified the insurance company he would hold it responsible for the whole of any judgment that might be recovered in the action; that the trial proceeded, and resulted in a verdict in favor of the plaintiff in that action in the sum of \$12,550, upon which judgment was entered; that the assured subsequently demanded that the insurance company pay the judgment, which it declined to do, and, after the time to appeal therefrom had expired, the assured, to prevent the issuance of an execution, and under protest, paid \$7,826.58, which, together with the sum of \$5,386.38 paid by the insurance company, satisfied the judgment; that by reason of the acts of the insurance company plaintiff was damaged to the extent of the amount paid by him, together with interest thereon from the date of payment.

In the second cause of action substantially the same facts are set forth, and in addition thereto it is alleged that after the entry of the judgment referred to the insurance company advised this plaintiff that reversible errors of law had been committed upon

the trial of the action; that the verdict was against the evidence, and it would therefore appeal from said judgment on behalf of the plaintiff, and from time to time thereafter assured the plaintiff that such appeal had been taken in his behalf; that there were reversible errors of law and the verdict was against the evidence; that, relying upon these statements, the plaintiff took no further steps with reference to an appeal; that, after the time to appeal had expired, the plaintiff ascertained that the insurance company, without his knowledge or consent, had neglected to take an appeal; that thereafter, to prevent the issuance of an execution upon the judgment, the assured paid \$7,826.58, having previously demanded that the insurance company pay the whole judgment, which it refused to do; that by reason of the insurance company having failed to take and prosecute the appeal plaintiff was damaged to the extent of the amount paid, viz., \$7,826.58, for which judgment was demanded, with interest.

The insurance company demurred to each cause of action on the ground that facts were not stated sufficient to constitute a cause of action. After the demurrer was interposed, both parties moved for judgment on the pleadings. The plaintiff's motion was granted, the insurance company's denied, and it appeals.

I am of the opinion that the facts alleged in the second cause of action, which were admitted by the demurrer, clearly state a liability on the part of the defendant. After the recovery of the judgment the insurance company notified this plaintiff that reversible errors had been committed; that the verdict was against the evidence, and it would appeal from the judgment. It subsequently stated to him that it had appealed, and by reason of that fact he permitted the time within which an appeal might have been taken by himself to expire. This, coupled with the allegation that there were reversible errors committed at the trial, and that the verdict was against the evidence, stated a cause of action.

The facts here pleaded bring the case within the rule laid down in *Rosenbloom vs. Maryland Casualty Co.*, 153 App. Div. 23, 137 N. Y. Supp. 1064, *Brassil vs. Maryland Casualty Co.*, 147 App. Div. 815, 133 N. Y. Supp. 187, affirmed 210 N. Y. 235, 104 N. E. 622, L. R. A. 1915A, 629, and *Attleboro Manufacturing Co. vs. Frankfort Marine Accident & Plate Glass Ins. Co. (C. C.)* 171 Fed. 495. The insurer, having elected and undertaken to defend the action brought against the assured, had no right, when it saw fit to do so, to abandon the defense. It was obligated to take into consideration the interest which the insured had, and especially so after judgment had been rendered which subjected him to a large liability. Having told him it would appeal from the judgment, there was an obligation resting upon it to do so, or else to have notified him, before the time to appeal had expired, that it would not take such appeal. It would be unreasonable to hold that the assured could be lulled into security by the assurance

that an appeal would be taken and thereby be deprived of the right to himself appeal, without liability attaching.

As to the first cause of action, I am of the opinion that it does not state facts sufficient to predicate liability. The most that can be said of the facts stated is that the insurance company would not permit this plaintiff to settle the action brought against him, or permit him to compromise any liability to which he might be subjected in that action, over and above the amount stipulated in the policy. This is precisely what he agreed in the policy issued to him he would not do. The policy is the contract between the parties. It definitely fixes their rights and obligations. The plaintiff expressly agreed that he would not, without the written consent of the insurance company, settle any claim or interfere in any legal proceeding. The fact that the proposed payment or settlement by him would not have increased the insurance company's liability is beside the question. It would have been a violation of his agreement, and it was for the insurance company to say whether or not it would permit him to do as he wished. Having deliberately entered into the contract, he had to abide by its terms.

The order appealed from, therefore, in so far as it grants plaintiff judgment on the first cause of action, is reversed, and defendant's motion for judgment in its favor granted, with leave to plaintiff to serve an amended complaint, and in so far as it grants plaintiff judgment on the second cause of action is affirmed, with leave to the defendant to withdraw its demurrer and answer. Settle order on notice.

Dowling, J., concurs.

Scott, J.

[1, 2] I concur in the result arrived at by Justice McLaughlin, but as to the first cause of action I place my concurrence upon the fact that plaintiff did not pay the \$3,750, which the injured person offered to accept. I do not understand that clause K of the contract would have stood in the way of such a payment. It does not absolutely forbid the insured to incur expenses or settle a claim without the written consent of the company, but merely provides that he may not so incur or settle, "except at his own cost." In other words, if he did incur expense or pay a sum in partial settlement, without the consent of the company, he could not recover the amount from the insurer. But if such payment would not increase the company's liability, or enhance its difficulties in defending the action, it would not amount to a breach of the contract.

Clarke, P. J., and Laughlin, J., concur.

AMERICAN MUT. LIABILITY INS. CO *vs.* COMMONWEALTH.*

(Supreme Judicial Court of Massachusetts. Suffolk.)

TAXATION—EXCISE TAX—INSURANCE CORPORATION—STATUTE.

Under St. 1909, c. 490, pt. 3 § 28, providing that insurance companies except life insurance companies and companies liable to taxation on their corporate franchises, shall pay an excise tax on all premiums received, and section 33, providing for certain deductions, but that dividends shall not be considered return premiums, "a tax or excise * * * on all premiums received," in view of the express provisions of section 33 being interpreted as meaning gross premiums and in view of the history of the statute (St. 1862, c. 224, §§ 1, 6, 9, allowing no deductions from the gross premiums, St. 1868, 165, § 1, providing for certain deductions, but that dividends shall not be construed to be return premiums, no substantial change having since been made, a domestic mutual insurance company was not entitled to deduct from its taxable amount a dividend of 30 per cent paid to its policyholders when their policies expired.

(For other cases, see *Taxation*, Cent. Dig. § 248; Dec. Dig. § 140.)

Case reserved from Supreme Judicial Court, Suffolk County.

Petition by the American Mutual Liability Insurance Company against the Commonwealth of Massachusetts for abatement of a corporation tax. Reserved for the full court on pleadings and agreed facts. Petition dismissed.

Sawyer, Hardy, Stone & Morrison, of Boston (Edward C. Stone, of Boston, of counsel), for Petitioner.

Henry C. Attwill, Atty. Gen., and Wm. Harold Hitchcock, Asst. Atty. Gen., for the Commonwealth.

* Decision rendered, May 19, 1916. 112 N. E. Rep. 868.

BAYER vs. BAYER ET AL. (No. 145.)*

(Supreme Court of Michigan.)

1. INSURANCE—EMPLOYERS' LIABILITY INSURANCE—ACCIDENTS ARISING OUT OF EMPLOYMENT—"OPERATION OF AND CONNECTION WITH BUSINESS."
A liability insurance policy, pursuant to Workmen's Compensation Act (Pub. Acts [Ex Sess.] 1912, No. 10), and limiting liability to accidents occurring in the operation of and in connection with the contracting and building business of the employer, does not cover the death of an employee, occurring while, at the direction of the employer, such employee was engaged in moving material for a third person, which work was in no way connected with the building business of the employer.

(For other cases, see Insurance, Cent. Dig. § 1144; Dec. Dig. § 435.)

Certiorari to Industrial Accident Board.

Action by Mary Bayer against Charles F. Bayer and others for compensation under the Workmen's Compensation Act. From an order of the Industrial Accident Board awarding compensation, defendants bring certiorari. Reversed, and order vacated.

Edward S. Grece, of Detroit, for Claimant.
Walters & Hicks, of Detroit, for Defendants.

* Decision rendered, June 1, 1916. 158 N. W. Rep. 109.

**AMERICAN SAV. BANK & TRUST CO. vs. NATIONAL SURETY CO. (No. 12976.)***

(Supreme Court of Washington.)

INSURANCE—FIDELITY INSURANCE—CONSTRUCTION OF BOND.

- A bond, indemnifying a bank against the dishonesty of its employees, separately stating the limit of liability growing out of the acts of each, giving the indemnitor the right to defend upon the ground of the previously known dishonesty of an employee, providing that the bank should render every assistance to aid in bringing such an employee to justice, and that the surety's liability should immediately terminate as to the subsequent acts of any employee, was in legal effect a separate bond as to each employee named in the schedule attached to it, so that the bank could not recover for a theft of which some one of three of its employees must have been guilty, the particular guilty one being undetermined.

(For other cases, see Insurance, Cent. Dig. §§ 384-390; Dec. Dig. 179.)

* Decision rendered, May 23, 1916. 157 Pac. Rep. 877.

Department 2. Appeal from Superior Court, King County; Walter M. French, Judge.

Action by the American Savings Bank & Trust Company against the National Surety Company. From a judgment of nonsuit and dismissing the action, plaintiff appeals. Judgment affirmed.

Hughes, McMicken, Dovell & Ramsey, of Seattle, for Appellant.
C. B. White, Skeel & Whitney, and Wright, Kelleher & Caldwell, all of Seattle, for Respondent.

LIFE.**UNITED STATES SUPREME COURT.****SUPREME LODGE, KNIGHTS OF PYTHIAS, PLFF. IN ERR.,****vs.****S. MIMS. (No. 345.)*****2. INSURANCE—BENEVOLENT SOCIETIES—REORGANIZATION
—MEMBERSHIP.**

A member of a voluntary unincorporated fraternal and benevolent association, the successor of an earlier corporation, became, upon incorporation under the act of June 29, 1894 (28 Stat. at L. 96, chap. 119), a member of the new corporation by virtue of his assent to § 3 of that act, providing that all claims, accounts, things in action, or other matters of business of whatever nature, now existing, for or against the present association, shall survive and succeed to and against the new corporation.

(For other cases, see Insurance, Cent. Dig. § 1840; Dec. Dig. § 705.)

**3. INSURANCE—BENEVOLENT SOCIETIES—CHANGES IN CON-
STITUTION—INCREASE OF RATES.**

The right of a fraternal and benevolent order, under its charter of June 29, 1894 (28 Stat. at L. 96, chap. 119), § 4, to amend its constitution at pleasure, provided that such constitution or amendments thereof do not conflict with the laws of the United States or of any state, extends to an increase in its insurance rates.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[3].)

**4. INSURANCE—BENEVOLENT SOCIETIES—CHANGES IN CON-
STITUTION—INCREASE OF RATES.**

A benevolent and fraternal order having power to alter and amend its constitution at will may raise its insurance rates, notwithstanding a clause in its laws that monthly payments of a member of the endowment rank shall continue the same so long as his membership continues, since this clause is not to be regarded as a contract, but as a regulation, subject to the possibility that a raise in rates may be necessary in order to pay benefits.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[3].)

**5. INSURANCE—BENEVOLENT SOCIETIES—REORGANIZATION
—INCREASE IN RATES.**

The assumption, under the act of June 29, 1894 (28 Stat. at L. 96, chap. 119), § 3, investing the fraternal order incorporated by that act with all "claims, accounts, debts, things in action, or other matters of business of whatever nature now existing for or against the present" unincorporated association, of an existing insurance contract with a member, cannot be deemed the assumption of a contract for immutable assessments, where both the old and new organizations possessed the power to amend their laws.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[3].)

* Decision rendered, June 12, 1916. Argued, May 1 and 2, 1916. 36 Sup. Ct. Rep. 702.

In error to the Court of Civil Appeals for the Fifth Supreme Judicial District of the State of Texas to review a judgment which affirmed, with a modification, a judgment of the District Court of Dallas County, in that state, in favor of plaintiff in a suit against a fraternal and benevolent order to recover back the dues paid by him as a member. Reversed.

See same case below.—*Tex. Civ. App.*—, 167 S. W 835.

The facts are stated in the opinion.

M. M. Crane, H. P. Brown, Edward Crane, James P. Goodrich, Ward H. Watson, James E. Watson, and Sol. H. Esarey for Plaintiff in Error.

Lawrence C. McBride, Joseph E. Cockrell, and Edward Gray for Defendant in Error.

HOLMES, J., delivered the opinion of the court.

This is a suit against a corporation chartered by Congress on June 29, 1894 (chap. 119, 28 Stat. at L. 96), to recover all sums paid by the plaintiff, the defendant in error, to the defendant and its predecessors; the ground alleged being that the defendant, the plaintiff in error, has demanded monthly dues in excess of its rights, and thereby has entitled the plaintiff to recover all that he had paid, with interest.

The facts are as follows: The plaintiff originally took out two certificates of insurance from an earlier corporation of the same name, the charter of which expired on August 5, 1890. In May, 1885, he surrendered these certificates and took out a new one in what was called the Fourth Class, by which in consideration of his original declaration and representations, and of the payment "of all monthly payments as required, and the full compliance with all the laws governing this rank, now in force, or that may hereafter be enacted and shall be in good standing under said laws," the sum of \$3,000 was to be paid to the plaintiff's wife, or such other beneficiary as he might direct in proper form, upon notice and proof of death and good standing at the time; provided, as hereafter stated. It was further stipulated that any violation of the conditions mentioned or the requirements of the laws governing this rank should avoid all claims. By the certificate of incorporation the corporation had power "to alter and amend its Constitution and by-laws at will;" the laws of 1880, then in force, provided that "these laws [regulating assessments *inter alia*] may be altered or amended at any regular session of the Supreme Lodge K. of P.;" and by his original application the plaintiff agreed to conform to the laws and regulations of the order then in force or that might thereafter be enacted, or submit to the penalties therein contained.

The plaintiff contends that his contract took him out of these reiterated provisions for possible change; and his ground is that by article 5, § 4, of the laws of 1884, creating the Fourth Class, the endowment fund for the payment of benefits in that class was to be derived from monthly payments from each member for each \$1,000 of endowment, to be graded according to the age of the member at the time of making application, and his expectancy

of life, the age to be taken at the nearest birthday, "Said monthly payments shall be based upon the average expectancy of life of the applicant, and shall continue the same so long as his membership continues." A table appended gave the rate for the different ages from twenty-one to sixty. At that time members were transferred to the Fourth Class at the original entry age, which, in the plaintiff's case, was forty-two. These same laws of 1884 repeated the former provision as to amendment by the Supreme Lodge, now requiring a two-thirds vote. The recension of 1886 repeated the last-mentioned provision, and set forth a form of application by which the applicant agreed not only, as heretofore, that he, but also that "this contract, shall be controlled" by the laws then in force or that might be enacted thereafter. The power to alter was applied in 1888 to the payments to be made by the Fourth Class. The board of control was ordered to rerate members transferred to the Fourth Class as the plaintiff was, so that thereafter they should pay as of the age at which they were transferred, instead of that at which they first became members. Thereafter the plaintiff paid as of the age of forty-eight.

After the charter expired, in 1890, the business was kept going under the same name by a voluntary association, the plaintiff paying his assessments as before, until on June 29, 1894, the act of Congress mentioned incorporated certain persons named, "officers and members of the Supreme Lodge Knights of Pythias," by the name of "The Supreme Lodge Knights of Pythias," and authorized them to use the powers "incidental to fraternal and benevolent corporations within the District of Columbia." By the 3d section of the charter "all claims, accounts, debts, things in action, or other matters of business of whatever nature now existing for or against the present Supreme Lodge Knights of Pythias, mentioned in § 1 of this act, shall survive and succeed to and against the body corporate and politic hereby created; provided that nothing contained herein shall be construed to extend the operation of any law which provides for the extinguishing of claims or contracts by limitations of time." This is the main ground upon which the defendant is sought to be charged with the certificate issued by the former corporation. By § 4 "said corporation shall have a constitution and shall have power to amend the same at pleasure; provided, that such constitution or amendments thereof do not conflict with the laws of the United States or of any state." Amendments to the laws of the association were adopted this same year, 1894, by one of which the existing rates were retained, and it was provided that each member of the endowment rank should continue to pay the same amount each month thereafter so long as he remained a member, "unless otherwise provided for by the Supreme Lodge or board of control of the endowment rank." A similar provision was made in 1900, but the rate for the age of forty-eight was made

\$2.45, or \$7.35 for the \$3,000 in the certificate. The plaintiff paid the rates as established from time to time.

The split came in 1910. In that year the corporation passed a law providing for a rerating of every member of the Fourth Class on January 1, 1911, in accordance with his attained age and occupation, under which the plaintiff's monthly payment would be raised to \$34.80, unless he accepted one of several options offered to him. It should be added that his occupation played no part, as it was not ranked as hazardous. He was notified, but declined to pay or otherwise accede to the change. On January 20, 1911, he tendered \$22.05 for the months of January, February, and March of that year, the tender was refused, and in May this suit was begun. The court of civil appeals affirmed a judgment for the plaintiff on a verdict directed by the trial court, modifying it so far as to confine the recovery to payments made since the issue of the certificate of 1885, with interest. An application to the Supreme Court for a writ of error was refused.

There is a motion to dismiss, but as the case necessarily will turn on the construction of the present charter, an act of Congress, and the defendant justifies under it, the motion is denied. *Creswill vs. Grand Lodge, K. P.* 225 U. S. 246, 258, 56 L. ed. 1074, 1078, 32 Sup. Ct. Rep. 822. There is no ground for treating the plaintiff as not having come into the new company by virtue of § 3. That section provided for his doing so, and when he was treated and acted as a member, the presumption is conclusive that he did so in pursuance of the law that authorized it.

We assume without argument that by § 3 of the charter, and his assent thereto, the plaintiff became a member of the organization, with whatever rights he might have as such. It is not to be conceived, however, that the charter was intended to create a privileged class, or that the right of the corporation to amend its laws was less in his case than in that of one joining after 1894. As to later members, we can have no doubt, notwithstanding the difference of opinion in state courts, that the right to amend extends to a change in the rates to be paid. Persons who join institutions of this sort are not dealing at arm's length with a stranger whose mode of providing for payment does not concern them, but only his promise to pay. They are joining a club the members of which have to pay any benefit that any member can receive. The corporation is simply the machine for collection and distribution. Its charter expressly provides by § 5 that it "shall not engage in any business for gain; the purpose of said corporation being fraternal and benevolent." It is manifest, therefore, that it would be a perversion of its purposes if, through some ambiguity of phrase, the necessary source of benefit were closed in favor of certain members, while their right to insist upon payment remained. The essence of the arrangement was that the members took the risk of events, and if the assessments levied at a certain time were insufficient to pay a benefit of a certain

amount, whether from diminution of members or any other cause, either they must pay more or the beneficiary take less.

The same conditions applied to the original corporation, and the plaintiff testifies that he understood them. He says in so many words that he knew that the only source of revenue to meet his and other policies was from assessments of the insured, and that if, after a proper rate was fixed for a membership of five thousand, the membership fell to two thousand, the rate would have to be increased if the obligations were to be met. The statute and the words of the law of the company under which the plaintiff entered the Fourth Class should be construed in the light of these considerations. In determining his rights it is important to bear in mind that there was no specific promise to him, like the promise to pay, in the certificate, but that his whole reliance is upon a law of the corporation; and that he had notice that all laws of the corporation were liable to be repealed. The only language in the certificate bearing on the matter pointed to possible changes, one condition being the payment of all monthly payments "as required." It was obvious and understood that, to pay a benefit, an increase in the assessment might be necessary. In our opinion the present charter, like the first, must be construed to authorize such an increase, and the clause in the law of 1884, relied upon,—that the payments should continue the same so long as the membership continued,—was not a contract, but was a regulation subject to the possibility inherent in the case. More than ambiguous words in an amendable law would be needed to establish a departure from the ground on which the relation of the parties obviously stood, and to create a privilege that attacked the corporation in its very life. Compare the language in Supreme Council, R. A. vs. Green, 237 U. S. 531, 542, 59 L. ed. 1089, 1100, L. R. A. 1916A, 771, 35 Sup. Ct. Rep. 724, and the same case below, sub nom. Reynolds vs. Supreme Council, R. A. 192 Mass. 150, 157, 7 L. R. A. (N. S.) 1154, 78 N. E. 129, 7 Ann. Cas. 776.

The persons incorporated in 1894 were described as officers and members of the Supreme Lodge then existing; that is, of a voluntary association; and it was the rights and duties of that association that the defendant assumed, if we are to take the words in their literal sense. We spend no time upon the inquiry what those rights and duties were, because, as we have said, we assume that the plaintiff acquired a standing in the new company. But in the second stage, as in the first, the law establishing the Fourth Class had received a practical construction as being open to change, by the continued rating of the plaintiff at forty-eight instead of forty-two, as at first, and although the plaintiff says in a general way that he protested, he paid, and he had notice of what the earlier companies asserted to be their rights when he came into the new one that asserted the same and put them in force as against him. We mention these details to show that the

plaintiff suffers no injustice and meets with no surprise when we state our opinion that the assumption under § 3 of the new charter of a relation with the plaintiff that originally arose under a law of the old corporation was not the assumption of a contract for immutable assessments, and decide that the power to amend, given by § 4, included the power to raise the rates to such point as was necessary for the corporation to go on.

The plaintiff's certificate did not absolutely promise to pay \$3,000 if the plaintiff had performed the conditions. It contained a proviso by which, if one monthly payment by members holding an equal amount of endowment should not be sufficient to pay the sum, the amount of the monthly payment should be the benefit received. If all other Fourth Class certificates were in similar form, it may be asked whether it was reasonable to increase the assessments rather than to allow the payments to abate. The answer, in addition to what we already have said, is that, unless the corporation continued to make substantial payments at death, it could not go on. On the evidence, at the end of 1910 the plaintiff's certificate was worth very little or nothing. It well may have been thought better to rehabilitate the class rather than to allow their certificates to become waste paper. At all events, that was the prevailing view in the republic to which the plaintiff belonged, and, as we have said, the charter authorized it to be enforced. It is unnecessary to discuss the options that were offered in the alternative, but it is proper to remember that for many years the plaintiff has been insured, and although by what he is not likely to regard as bad fortune his beneficiary has not profited by it, she would have if he had died. As he happily has lived, he has to bear the burdens incident to the nature of the enterprise into which he went open-eyed.

Judgment reversed.

UNITED STATES SUPREME COURT.

MUTUAL LIFE INSURANCE COMPANY OF NEW YORK, PETITIONER,
vs.

L. HILTON-GREEN AND W. A. FINLAY, JR., AS EXECUTORS OF THE
ESTATE OF C. L. WIGGINS, DECEASED. (No. 126.)*

1. INSURANCE — FALSE REPRESENTATIONS — FRAUDULENT INTENT.

Material incorrect representations in the application for a policy of life insurance, which is made an essential constituent of the policy, if known to be untrue by the assured when made, invalidate the policy without further proof of actual, conscious design to defraud.

(For other cases, see *Insurance, Cent. Dig.* § 549; *Dec. Dig.* § 256 [1].)

* Decision rendered, June 12, 1916. Argued, Dec. 9 and 10, 1915. 36 Sup. Ct. Rep. 676.

3. INSURANCE — ESTOPPEL — AGENT'S KNOWLEDGE—FRAUDULENT MISREPRESENTATIONS.

The designation as agents of an insurance company, made by Florida Gen. Stat. § 2765, of any person who in anywise, directly or indirectly, makes or causes to be made any contract of insurance for or on account of such insurance company, does not affect the true relationship to the parties to a life insurance contract of the local manager, soliciting agent, and local medical examiners, who were in fact designated agents of the company, with power to bind it within their apparent authority, and their knowledge of the falsity and fraudulent character of material representations by the insured in the application, which is made an essential constituent of the policy, is not the knowledge of the company, and does not estop it to rely upon such misrepresentations as a defense to an action on the policy.

(For other cases, see Insurance, Cent. Dig. §§ 969, 971, 973, 974, 977-997; Dec. Dig. § 378[3].)

On writ of certiorari to the United States Circuit Court of Appeals for the Fifth Circuit to review a judgment which affirmed a judgment of the District Court for the Northern District of Florida in favor of plaintiffs in an action upon policies of life insurance. Reversed and remanded for further proceedings.

See same case below, 127 C. C. A. 467, 211 Fed. 31.

The facts are stated in the opinion.

Frederick L. Allen, Emmett Wilson, Philip D. Beall, and Murray Downs for Petitioner.

William A. Blount, A. C. Blount, and F. B. Carter for Respondents.

McREYNOLDS, J., delivered the opinion of the court.

Respondents sued to recover upon four policies, not different except as to numbers, for \$7,662 each, and dated December 16, 1908, on the life of their testator, Wiggins, who died March 26, 1910. By various pleas the insurance company set up that application upon which policies were based contained material representations both false and fraudulent. In reply the executors denied truth of each plea, and also alleged that if application contained any misrepresentations, the actual circumstances were known to company when policies issued.

Two separate application blanks, each plainly printed upon a large, single sheet, were filled out and presented. They are substantially identical except medical examiner's report upon one, dated December 15, 1908, is signed by Geo. C. Kilpatrick, M. D., in two places, while the other, dated December 16, 1908, is twice signed by J. S. Turberville, M. D. (Under the company's rules, where insurance applied for amounted to \$30,000, two medical examinations were required.)

At the top of each sheet the following appears: "THIS APPLICATION made to the Mutual Life Insurance Company of New York is the basis and a part of a proposed contract of insurance, subject to the charter of the company and the laws of the state of New York. I hereby agree that all the following statements and answers, and all those that I make to the company's

medical examiner, in continuation of this application, are by me warranted to be true, and are offered to the company as a consideration of the contract, which I hereby agree to accept, and which shall not take effect unless and until the first premium shall have been paid, during my continuance in good health, and unless also the policy shall have been signed by the president and secretary and countersigned by the registrar of the company and issued during my continuance in good health; unless a binding receipt has been issued as hereinafter provided."

Immediately thereafter are statements concerning assured's address, occupation, birth, character of policy desired, etc., and finally this, alleged and shown to be untrue: "22. I have never made an application for life insurance to any company or association upon which a policy has not been issued on the plan and premium rate originally applied for, except as to the following companies or associations: None, and no such application is now pending or awaiting decision." And this part of the paper concludes:—

"Dated at Pine Barren, Fla., Dec. 15, 1908.

"Signature of person whose
life is proposed for insurance} Cilbey L. Wiggins

"I have known the above named applicant for six years and saw him sign this application. I have issued binding receipt No. _____. J. D. Torrey, Soliciting Agent,

[by rubber stamp]

"J. D. Torrey, Manager,
"Mobile, Ala."

On lower portion of the same page, under caption, "Medical Examiner's Report," are sundry statements, ostensibly by applicant, concerning his health history, etc.,—among them the following, alleged and shown to be untrue:—

"3. (a) What illnesses, diseases, or accidents have you had since childhood? Pneumonia. Number of attacks: One. Date of each: 1899. Duration: Thirty days. Severity: Not severe. Results: Complete recovery.

"4. State every physician whom you have consulted in the past five years. None."

"8. Have you undergone any surgical operation? No."

"13. (a) Have you ever been under treatment at any asylum, cure, hospital, or sanitarium? No."

"16. Have you ever been examined for a policy in any company or association which was not issued as applied for? No."

This division ends thus:—

Dated at Pine Barren, State of Florida the 15 day of December 1908

Witness:

Geo. C. Kilpatrick,
M. D.

I certify that my answers to the foregoing questions are correctly recorded by the Medical Examiner.

Cilbey L. Wiggins. Signature of person examined.

At the top of reverse page, under "Medical Examiner's Report (Continued)," there are many answers purporting to be replies to inquiries propounded by medical examiner concerning applicant's figure, apparent age, measurements, pulse, results of physical examination and personal investigations, etc. And then the following:—

I certify that I have made this examination at Pine Barren, Fla., on this 15 day of December, 1908, and that the foregoing questions have been put, and the answers of the applicant recorded as stated.

Geo. C. Kilpatrick,
M. D.

Medical Examiner.

The four policies, after being signed in New York by the president, secretary, and registrar of the company, were delivered to assured in Florida. Among others, they contain these clauses:—

"This policy and the application herefor, copy of which is indorsed hereon or attached hereto, constitutes the entire contract between the parties hereto. All statements made by the insured shall, in the absence of fraud, be deemed representations, and not warranties, and no such statement of the insured shall avoid or be used in defense to a claim under this policy unless contained in the written application herefor, a copy of which is indorsed hereon or attached hereto." "Agents are not authorized to modify this policy or to extend the time for paying a premium."

During summer of 1907 assured suffered serious pains in his head, and, after consulting more than one physician, went to a sanitarium at Montgomery, Ala., and was there operated on for a cystic enlargement of the lower jaw caused by an impacted wisdom tooth. He was confined to the sanitarium for ten days and remained under immediate care of a physician from July 16th to August 13th, 1907.

Early in November, 1908, he applied to Prudential Insurance Company of America through J. C. Hogue, a special agent operating under J. R. Tapia, its manager at Mobile, Alabama, for insurance amounting to \$40,000. The application was accompanied, according to its requirements, by two medical reports dated November 3d and 4th, signed respectively by Dr. J. C. McLeod and Dr. Geo. C. Kilpatrick. Several weeks later the company indi-

cated unwillingness to accept risk because of location, but the application, although marked "withdrawn," was retained. At this time Wiggins had \$30,000 insurance with the Prudential, \$20,000 with the Equitable, and \$5,000 with fraternal insurance companies.

The application of petitioner now under consideration resulted from earnest and persistent solicitation by the same J. C. Hogue. The circumstances under which papers were prepared and signed are not entirely clear; but it appears without contradiction that they were not signed by assured in Torrey's presence—there was no personal acquaintance between the two men. Also that neither medical report was signed by assured in presence of Dr. George C. Kilpatrick or Dr. J. S. Turberville; and that neither physician made the personal examination certified by him. The physicians filled the blanks and signed their names at Hogue's request and because of his representations. Through Torrey, petitioner's district manager at Mobile, the application was forwarded to New York, and, relying upon its statements, officers there issued policies and sent them to assured with copies of application papers which, by reference, were incorporated therein. So far as appears, assured accepted without objection and paid the premiums.

An effort was made to show that facts concerning Wiggins's medical history, former unsuccessful application to Prudential, and circumstances surrounding transactions now in question, were known by Hogue, the medical examiners, or Torrey, each of whom, it is claimed, was petitioner's agent.

Assured was sixty-one years of age, president of a lumber company, apparently a man of considerable wealth, and experienced in insurance matters.

At conclusion of evidence, counsel for insurance company asked a directed verdict. This was refused; and the court in effect instructed the jury: That in order for company successfully to defend upon ground of false statements, these must have been material, and made by Wiggins with knowledge of their falsity, and with a fraudulent purpose—that is, with intent to deceive. That if they believed it knew of their falsity when application was accepted, no defense could be based upon them. That it knew the actual facts if the jury "should find that an agent whose knowledge would be the knowledge of the defendant did so know." But if the jury found that falsity of statements was within knowledge of Hogue and Torrey and medical examiners, and further found an understanding, tacit or express, between Wiggins and said agents to procure the policies by collusive co-operation to conceal the truth, there could be no recovery. Excerpts which follow fairly indicate general import of charges:

"The contract of insurance in this case as expressed by the policies, embraces the statements and representations of Wiggins, the deceased, made to the agent, Hogue, or to Kilpatrick, or Turberville, the medical examiners. Such statements were required to be truthfully made, and was a condition for the issu-

ance of the contract, and this contract provides that all statements made by the insured shall in the absence of fraud, be deemed representations, and not warranties. Whether the representations made by Wiggins in his application for insurance had been rejected; or whether he had been treated in a cure, sanitarium, or hospital; or whether he had undergone a surgical operation; or whether he had had any illness or disease; or whether he had consulted a physician for his health, to serve as a defense by the company to this action, depends on whether such statements were knowingly false and fraudulently made.

"If Wiggins knew they were false, and that he made them with the fraudulent purpose of obtaining the policy of insurance, then such statements would avoid the policy and would serve as a good defense by the company; provided, that the company, at the time it accepted the application of the deceased as an insurance risk, had no knowledge of the falsity of the statements and representations made by Wiggins in his application for insurance.

"The knowledge of the agent of the insurance company would be the knowledge of the company, and if the agent representing the company in taking the application, or the statements of the medical examiners, had knowledge of the falsity of the statements, then the insurance company would be estopped from setting up such false statements or misrepresentations of which they had knowledge before the issuance of the policy, as a defense to this action.

* * * * *

"If you find from the evidence that the statements of Wiggins in the several matters inquired about his health and operation and treatment in a sanitarium were false, and further find that the agents Hogue and Torrey and Turberville, knew they were false, and you further find from the evidence that there was an understanding, tacit or expressed, between Wiggins and the said agents to procure the policies by collusive co-operation to conceal the truth from the company as to the several matters inquired about, then such conduct upon the part of Wiggins would avoid the policies, and the plaintiffs could not recover in this action."

Petitioner made timely objections and presented special requests, setting forth its theory, which were denied. The circuit court of appeals affirmed a judgment upon verdict for respondents. Among other things it said (127 C. C. A. 467, 470, 471, 211 Fed. 31, 34, 35) :—

"That, under the language of the policies involved in this suit, the defendant, to avoid the policies for false representations, must establish their falsity, materiality, and the knowledge of the insured, actual or imputed, of their falsity.

* * * * *

"This leaves for consideration the representation of the insured that he had been examined by Dr. Turberville, defendant's

medical examiner, and that the answers recorded by the medical examiner in his report were correct. In truth, there was no such examination had, and the insured must have known that there was none, and the representation that there had been one was a material one. So with regard to the representations of the insured that there had been no previous application for insurance made by him and rejected, or not passed upon favorably by the insurance company. This was untrue, but must have been known to have been untrue by the insured when he made it, and it was material. Either of these two last representations would be sufficient to avoid the policies, unless the defendant is estopped to rely upon them, by reason of its knowledge of their falsity. It had such knowledge, if at all, because of the knowledge of its agents and examiners, who handled the matter for it."

And further (p. 37) : "The statute [§ 2765, General Statutes of Florida—copied in margin] prescribes that every person who receives money for an insurance company in payment of a contract of insurance, or who directly or indirectly causes to be made any contract of insurance, shall be deemed to all intents and purposes an agent or representative of such company. Under this description, we think Torrey, the defendant's Mobile manager, Hogue, the soliciting agent, and the two medical examiners, were agents of the defendant to all intents and purposes, and so far for the purpose of charging it with notice of what they knew, when the policies were written."

All parties treat the policies as Florida contracts. The medical examiners' reports are plainly integral parts of application, and by apt words the latter became an essential constituent of the policies.

Considered in most favorable light possible, the above quoted incorrect statements in the application are material representations; and, nothing else appearing, if known to be untrue by assured when made, invalidate the policy without further proof of actual conscious design to defraud. *Moulor vs. American L. Ins.*

[“2765. Agents.—Any person or firm in this state, who receives or receipts for any money on account of or for any contract of insurance made by him or them, or for such insurance company, association, firm or individual, aforesaid, or who receives or receipts for money from other persons to be transmitted to any such company, association, firm or individual, aforesaid, for a policy of insurance, or any renewal thereof, although such policy of insurance is not signed by him or them, as agent or representative of such company, association, firm or individual, or who in any wise directly or indirectly makes or causes to be made, any contract of insurance for or on account of such insurance company, association, firm or individual, shall be deemed to all intents and purposes an agent or representative of such company, association, firm, or individual.”]

Co., 111 U. S. 335, 345, 28 L. ed. 447, 450, 4 Sup. Ct. Rep. 466; Phoenix Mut. L. Ins. Co. vs. Raddin, 120 U. S. 183, 189, 30 L. ed. 644, 646, 7 Sup. Ct. Rep. 500; Ætna L. Ins. Co. vs. Moore, 231 U. S. 543, 556, 557, 58 L. ed. 356, 365, 366, 34 Sup. Ct. Rep. 186; May, Ins. 4th ed. § 181.

The general rule which imputes an agent's knowledge to the principal is well established. The underlying reason for it is that an innocent third party may properly presume the agent will perform his duty and report all facts which affect the principal's interest. But this general rule does not apply when the third party knows there is no foundation for the ordinary presumption,—when he is acquainted with circumstances plainly indicating that the agent will not advise his principal. The rule is intended to protect those who exercise good faith, and not as a shield for unfair dealing. Distilled Spirits (*Harrington vs. United States*), 11 Wall. 356, 367, 20 L. ed. 167, 171; American Surety Co. vs. Pauly, 170 U. S. 133, 156, 42 L. ed. 977, 985, 18 Sup. Ct. Rep. 552; American Nat. Bank vs. Miller, 229 U. S. 517, 521, 522, 57 L. ed. 1310, 1312, 1313, 33 Sup. Ct. Rep. 883; Mechem, Agency, 2d ed. § 1815.

Section 2765 of the Florida statutes, *supra*, undertakes to designate as agents certain persons who in fact act for an insurance company in some particular; but it does not fix the scope of their authority as between the company and third persons, and certainly does not raise special agents, with limited authority, into general ones, possessing unlimited power. We assume Hogue, Torrey, and the medical examiners were in fact designated agents of the company, with power to bind it within their apparent authority; and in such circumstances the statute does not affect their true relationship to the parties. See *Continental L. Ins. Co. vs. Chamberlain*, 132 U. S. 304, 310, 33 L. ed. 341, 343, 10 Sup. Ct. Rep. 87; *New York L. Ins. Co. vs. Russell*, 23 C. C. A. 43, 40 U. S. App. 530, 77 Fed. 94, 103; *Wood vs. Firemen's F. Ins. Co.*, 126 Mass. 316, 319; *John R. Davis Lumber Co. vs. Hartford F. Ins. Co.*, 95 Wis. 226, 234, 235, 37 L. R. A. 131, 70 N. W. 84.

The assured at the least consciously permitted an application containing material misrepresentations to be presented by subordinate agents to officers of the insurance company under circumstances which he knew negatived any probability that the actual facts would be revealed; and later he accepted policies which he must have understood were issued in reliance upon statements both false and material. He could claim nothing because of such information in the keeping of unfaithful subordinates. Moreover, the false representations accompanied and were essential parts of the policies finally accepted. He did not repudiate, and therefore adopted and approved, the representations upon which they were based. Beyond doubt an applicant for insurance should exercise toward the company the same good

faith which may be rightly demanded of it. The relationship demands fair dealing by both parties. *New York L. Ins. Co. vs. Fletcher*, 117 U. S. 519, 529, 533, 534, 29 L. ed. 934, 939, 940, 6 Sup. Ct. Rep. 837; *Northern Assur. Co. vs. Grand View Bldg. Ass'n*, 183 U. S. 308, 361, 46 L. ed. 213, 234, 22 Sup. Ct. Rep. 133; *United States L. Ins. Co. vs. Smith*, 34 C. C. A. 506, 92 Fed. 503.

Considered with proper understanding of the law, there is no evidence to support a verdict against petitioner, and the trial court should have directed one in its favor.

Judgment of the Circuit Court of Appeals is reversed and the cause remanded to the United States District Court, Northern District of Florida, for further proceedings in accordance with this opinion.

Reversed.

Mr. Justice Pitney dissents.

SPRINGFIELD COURT OF APPEALS.

MISSOURI.

LYKE

vs.

AMERICAN NAT. ASSUR. CO. (No. 1732.)*

1. INSURANCE—PREMIUMS—PAYMENT.

Where a life policy provided that it should not go into effect until payment of the first premium, the fact that the agent delivered it and personally paid the amount of the premium, less his commission, pursuant to his agreement with the insurer, did not operate as the payment of the first premium, making the policy effective.

(For other cases, see *Insurance, Cent. Dig.* §§ 235-242; *Dec. Dig.* § 137[3].)

3. INSURANCE—LIFE POLICY—TIME OF GOING INTO EFFECT.

Where insured receives a life policy different from the one applied for, he must reject it within a reasonable time after delivery, and retention of the policy without objection beyond such reasonable time is proof of acceptance. Therefore, where insured received a life policy in August, and did not at that time return a receipt attached to the policy which directed that the receipt should be signed and returned when the policy was delivered, insured cannot in December, by writing across the face of the policy "Accepted" and his name, put the policy into effect as of that date, thus delaying time for payment of subsequent premiums; this being particularly true as the receipt was signed and

* Decision rendered, June 24, 1916. 187 S. W. Rep. 265.

dated as of the time of delivery of the policy, but was not detached.
the first premium, not having been paid by insured.

(For other cases, see Insurance, Cent. Dig. §§ 222-224, 229, 230; Dec. Dig. § 136[5].)

Appeal from Circuit Court, Jasper County; D. E. Blair, Judge.
Action by Anna C. Lyke against the American National Assurance Company. From a judgment for defendant, plaintiff appeals. Affirmed.

Oscar B. Elam, of Aurora, for Appellant.
Jones, Hocker, Sullivan & Angert, of St. Louis, John L. McNatt, of Aurora, and George F. Haid, of St. Louis, for Respondent.

STURGIS, J.

The trial court sustained a demurrer to plaintiff's evidence in this suit on a policy of life insurance issued by defendant. The salient facts lie within a small compass. The policy is dated August 11, 1913, and was then issued on the application of the insured, Winfred B. Lyke, in favor of plaintiff as beneficiary. Both the application and the policy provide that the policy shall not take effect until the first premium of \$109.53 has been actually paid and the policy delivered to the applicant during life and good health. No premium was actually paid by the insured. The policy also provides that the insurance is granted in consideration of the application and of the payment in advance of the premium mentioned for the first policy year ending August 11, 1914; that the contract will be continued upon the payment of an annual renewal premium of like amount on or before August 11, 1914, and of the payment thereafter of a like sum on or before the 11th day of August in each year during the continuance of the policy or until the prior death of the insured; that after delivery of the policy to the insured it takes effect as of its date, August 11, 1913.

The insured died December 16, 1914, more than four months after the second premium became due, counting from the date of the policy. This premium was not paid. The policy also provides that, if any premium or installment thereof is not paid when due, the policy shall ipso facto be null and void, and all premiums forfeited to the company, except as otherwise provided.

[1] The plaintiff seeks to avoid the force and effect of the failure of the insured to pay the first premium, the effect of which is that the policy never became a live contract, by showing that the defendant company had an agency contract with the agent through whom the policy was applied for by which it lost nothing by the insured's failure to pay the premium to the agent. The substance of that contract, so far as material here, is that the defendant received all applications and issued all policies within the agency territory through this agent, who collected all first premiums and retained, as his commission, a large part

thereof; that when applications were received through his agency and accepted by the company the policies were then forwarded to this agent, who delivered same and collected the first premium; that this agent was charged with the net amount of premiums due the defendant on all policies sent to him for delivery, and he must settle for same with the defendant company within sixty days from the delivery of the policy to him unless returned to the company, except that when notes were taken for the premiums he must then settle for same within ninety days. It will be readily seen that this contract was an arrangement and agreement solely between the company and its agent to facilitate and safeguard the transaction of business between them, by which the company looked to the agent, and held him responsible, for all premiums on policies delivered to him by the company for applicants and not returned to the company within the stipulated time. The agent took the risk of collecting from the applicant and, if he chose to indulge an applicant it was his personal risk. Under this arrangement a payment of any such premium by the applicant to the agent would be a payment to the company whose agent he was, but a payment by the agent to the company was not a payment for the applicant whose agent he was not.

In the present case we will grant that the evidence is sufficient to show that defendant's agent, by reason of having indulged the insured beyond the period allowed, did in fact pay over to defendant its portion of the first premium on this policy, and thereafter tried to induce the insured to repay the same; yet we do not think this fact made a valid contract of insurance in favor of the insured. This exact point was decided in *Whiting vs. Insurance Co.*, 129 Mass. 240, 37 Am. Rep. 317, though in that case the third party paying the premium did so for the insured's benefit. Here the agent did not pay his company this net premium for the benefit of the insured, or with the intention of keeping the policy alive for his benefit, but solely because it became a debt of his own. The agent was not even making a contract for the benefit of the insured. He was merely accounting for funds which, so far as the company was concerned, were regarded as being in his hands. As stated in the above-cited case, there was no insurance contract, because there was no meeting of the minds of the company and the insured. The settlement between the agent and the company was res inter alios acta.

[2] Nor does this case come within the rule of *Dobyns vs. Bay State Beneficiary Ass'n*, 144 Mo. 95, 45 S. W. 1107, and *Gibson vs. Insurance Co.*, 181 Mo. App. 302, 168 S. W. 818, that, where the policy expressly recites the advance payment of the initial premium, such fact cannot be controverted by parol evidence. Here there is no recital in the policy that the first premium had been paid. The whole contract, consisting of the application and policy, shows that it was contemplated that the

first premium should not be paid till its delivery and acceptance by the insured, and it is competent to show that this was never done. 5 Elliott on Contracts, § 4358. Since the payment of the first premium was a condition precedent to the policy becoming a binding contract, the policy never went into force. Giddings vs. Insurance Co., 102 U. S. loc. cit. 111, 26 L. Ed. 92; Brown vs. Insurance Co., 59 N. H. 298, 47 Am. Rep. 205; Whiting vs. Insurance Co., 129 Mass. 240, 37 Am. Rep. 317.

[3] We also think that, even if the policy came into life by the payment or waiver of payment of the first premium, it was thereafter forfeited by failure to pay the second premium within thirty days of the due date thereof, as the policy provides. The plaintiff seeks to avoid this by claiming that the policy did not go into force and effect till its delivery and acceptance by the insured, and that the insured did not accept the policy until December 31, 1913; that the first year's premium kept the policy in force one year from the last-named date, or to December 31, 1914, and the insured died within that time. The plaintiff relies on Halsey vs. Insurance Co., 258 Mo. 659, 167 S. W. 951, as sustaining this theory. The facts do not justify this conclusion. The policy bears date August 11, 1913, and was registered by the state insurance department on August 13, 1913. A form of receipt which evidently accompanied the policy and contained the direction that upon the delivery of the policy this receipt should be signed by the insured and mailed immediately to the company bore date of August 20, 1913, over the insured's signature, and was found along with the policy among the insured's effects after his decease. It is evident, therefore, that the policy was delivered to the insured at or about this last date.

No formal act of acceptance of this policy was called for or required; as the form of receipt, had it been returned to the company as requested, was merely for its information that the policy had been delivered. The policy issued and tendered to the insured was in exact accord with that applied for, and there was no need of any acceptance further than the payment of the first premium and retention of the policy. The insured's consciousness that he had not paid this first premium and that the policy was therefore worthless accounts for his not returning the formal receipt acknowledging the delivery of the policy. Even if the insured had paid the first premium or given an obligation therefor and the policy delivered was different than that applied for, the insured would be required to reject same within a reasonable time after delivery to him, and the retention of the policy without objection beyond such reasonable time is proof of acceptance. Insurance Co. vs. Neiberger, 74 Mo. 167; Robertson vs. Tapley, 48 Mo. App. 239, 242; Gray vs. Blackwood, 112 Ark. 332, 165 S. W. 958.

It is true that across the face of this form of acknowledgment of the delivery of the policy, which was found among the de-

ceased's effects, appear the words, "Accepted 12—31—1913, W. D. Lyke," and there is some evidence that this notation is in the handwriting of the insured. But, if so, it was purely an ex parte act of the insured, unknown and unassented to by the defendant. To hold that the insured could thus arbitrarily and indefinitely postpone the taking effect of the policy and prolong at his pleasure the due date of the next premium, and, in effect, obtain insurance for a year and four months on payment of one premium (which as we have seen was not paid), is repugnant to our conception of both law and justice.

This policy itself declares that after delivery to the insured it takes effect as of its date, August 11, 1913, which is contracted to mark the beginning and end of each policy year. But it is not necessary to hold that the terms of this policy so differ from the one before the court in *Halsey vs. Insurance Co.*, 258 Mo. 659, 167 S. W. 951, that the acceptance of this policy related back to the date of the policy. It is sufficient to hold, as we do, that the acceptance of this policy, if there was any acceptance, was within a reasonable time after its delivery to the insured, and that the second premium was due one year after such date; that it was not paid within such period and the policy lapsed.

This cause might well have been disposed of on a bare statement of the facts showing that no premium was ever paid on this policy, either in cash or otherwise, and that plaintiff is seeking to reap where she has not sown—to get something for nothing. We will also say, as an additional and sufficient reason for affirming the judgment, that appellant has grievously sinned against our rule requiring the appellant to abstract the record.

The judgment is therefore affirmed.

Robertson, P. J., and Farrington, J., concur.

SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, THIRD DEPARTMENT.

GUNTRUM

v.s.

PRUDENTIAL INS. CO. OF AMERICA.*

1. INSURANCE—WAIVER—ENTRY OF PREMIUMS IN RECEIPT BOOK.

The requirement in a policy that "payments to be recognized by the company must be entered at the time of payment in the premium receipt book belonging to the policy, may be waived by the company's receiving

* Decision rendered, June 30, 1916. 159 N. Y. Supp. 1006.

and retaining premium payments, where there is no dispute between the policyholder and its agent as to whether payments have been made. (For other cases, see Insurance, Cent. Dig. § 1041; Dec. Dig. § 392[1].)

2. INSURANCE—WAIKER—POWER OF COMPANY.

While an agent may not waive the conditions of a policy, the company may do so.

(For other cases, see Insurance, Cent. Dig. §§ 943-946; Dec. Dig. § 371.) Woodward, J., dissenting.

Appeal from Trial Term, Albany County.

Action by Elizabeth Guntrum, as administratrix, against the Prudential Insurance Company of America. From a judgment for plaintiff, and an order denying new trial, defendant appeals. Affirmed.

Argued before Kellogg, P. J., and Lyon, Howard, Woodward, and Cochrane, JJ.

Amasa J. Parker, Jr., of Albany, for Appellant.

William Goldberg, of Albany (Louis J. Rezzemini, of Albany, of counsel), for Respondent.

HOWARD, J.

The insurance policy upon which this action is based requires that "payments to be recognized by the company must be entered at the time of payment in the premium receipt book belonging to this policy." And it also provides that "after the expiration of the said period of grace (four weeks) the company's liability under this policy shall cease." The policy was written August 5, 1912; the insured died October 25, 1912. Six payments are entered upon the receipt book belonging to this policy, the last one being due September 9, 1912. If there were no valid payments made upon this policy after September 9, 1912, the company's liability had ceased on October 25, 1912; the premiums having been in arrears at that time for a period exceeding four weeks. But the plaintiff offered evidence that all payments had been made to, and accepted by, the company up to October 21, 1912. The jury has given credit to this evidence and found the facts to be as alleged by the plaintiff. We are not disposed to upset this verdict as being against the weight of evidence. Therefore the question arises whether the payments made subsequent to September 9th, they not having been entered in the premium receipt book, are valid.

[1, 2] Philip Jacobs, who was the agent of the defendant having in charge the collections of the premiums due on this policy, testified:—

"He [the insured] never had a premium receipt book. I would give him a receipt at different times. * * * Whenever I met him he would pay me for his insurance premium. I would enter it in my collection book and give him receipts. * * * My payments were always turned in every week at the office, and his premiums were turned into the office by me; I think I was pay-

ing them between the 18th day of September and the 25th of October, 1912. * * * He was always within the limit, and therefore he was not in arrears, and nothing to keep the insurance company from paying the claim. My collection book will show all this."

The collection book was introduced in evidence and shows all payments up to October 21st. Jacobs also testified that the insured made no payments to him after September 18, 1912. It thus appears from this evidence that Jacobs was making the payments for the insured; that is to say, although the insured did not pay his premiums to Jacobs as they became due, Jacobs paid them to the company as they became due, and the company received the money and has kept it. By doing so the defendant must be held to have waived the clause of the policy which requires the entry in the receipt books of all payments; for, while an agent may not waive the conditions of a policy, the company may do so. If the plaintiff had been able only to make proof of payments to the agent, such payments, of course, under the terms of the policy, unless entered in the receipt book, would not be binding upon the company; but here the plaintiff has traced every payment due to the defendant into the coffers of the defendant—payments which remain there yet. The agent was advancing these payments under an arrangement with the insured, but the company received the money as effectively as though the insured had paid it to Jacobs and had caused the payment to be noted in the receipt book. The clause in the policy which requires all payments to be entered in the receipt book seems to have been inserted to protect the company against disputes between policy-holders and agents as to whether payments have been made. But the company cannot invoke this clause when there is no such dispute, and when it has actually received and kept the premium payments.

The judgment and order should be affirmed. All concur, except Woodward, J., who dissents.

SUPREME COURT OF SOUTH DAKOTA.

HALL

vs.

DAKOTA MUT. LIFE INS. CO. (No. 3922.)*

1. INSURANCE — WAIVER — WHAT CONDITIONS MAY BE WAIVED.

The condition in a policy or premium notes of forfeiture of policy for nonpayment of premium may be waived.

(For other cases, see Insurance, Cent. Dig. § 941; Dec. Dig. § 372.)

2. INSURANCE — LIFE INSURANCE — ACTIONS — WAIVER OF FORFEITURE—EVIDENCE.

In action upon a life insurance policy, premium notes having been given and being unpaid at death of insured, letters of insurer, calling attention to the nonpayment and the necessity of prompt payment to "save the policy from lapsing," held a waiver of forfeiture for nonpayment.

(For other cases, see Insurance, Cent. Dig. § 1041; Dec. Dig. § 392[2].)

Appeal from Circuit Court, Codington County; C. G. Sherwood, Judge.

Action by Frances Hall, administratrix, against the Dakota Mutual Life Insurance Company. From a judgment for plaintiff and order denying new trial, defendant appeals. Affirmed.

Hanten & Hanten and Perrett F. Gault, all of Watertown, for Appellant.

E. B. Harkin, of Aberdeen, for Respondent.

POLLEY, P. J.

In this action plaintiff seeks to recover on a policy of life insurance. The defense is forfeiture of the policy because of non-payment of the premium. The policy is a twenty-payment life policy, and was issued on the 10th day of June, 1908. The premiums were to be paid annually in advance, and the first annual premium was paid when the policy was issued. On July 10, 1909, the second annual premium was paid and accepted by defendant. On July 11, 1910, the third annual premium was paid and accepted. The fourth annual premium, due on the 10th day of June, 1911, was not paid; but on the 15th day of August, 1911, the insured gave his note for the amount of said premium payable on the 1st day of January, 1912. This note contained the following condition:—

"If this note, given for the premium due June 10, 1911, on policy No. 1316, is not paid when due and before the death of the insured, then said policy contract shall be null and void and not enforceable."

* Decision rendered, June 27, 1916. 158 N. W. Rep. 449.

This note was not paid when due, and on the 26th day of January, 1912, the insured gave the defendant a renewal note in a similar amount, due on or before the 1st day of June, 1912, and containing the same forfeiture clause that is found in the first. This renewal note was not paid when due, or at all.

On the 9th day of July, 1910, the insured made a loan of \$230 from defendant on the said policy and, on that date, executed and delivered to the defendant his note for that amount payable on the 9th day of July, 1911, with interest thereon payable in advance at the rate of 5 per cent per annum. A year's interest was paid in advance at that time. This note, among other conditions, contained the following:—

"That in the event of the death of the insured before the payment of this loan, then this note shall at once become due and payable, and the sum due hereon for principal and interest shall be deducted from any amount payable under said policy.

"That in case of failure to pay either principal or any installment of interest at maturity, or failure to pay when due any premium on said policy, or any note given therefor, and such default shall continue for a period of thirty days, the whole principal of this note, shall, at the option of said Dakota Mutual Life Insurance Company, become due and payable, and said Company may, and it is hereby expressly authorized, without notice, to cancel and surrender the said policy, and all obligation of said company shall cease thereon, except as hereinafter provided.

"It is agreed that if default be made in the payment of any premium upon said policy or in the payment hereof, either principal or interest, then this note shall become payable at once, and in that event I hereby elect to take the cash surrender value of said policy at the date of such default, and I hereby empower said insurance company to cancel said policy upon its books, and, after taking out all sums due upon said note and said policy, the balance, if any, to be forwarded to me.

"This note may be paid in one year from date, or at any interest date thereafter."

Nothing was paid on this note until the 26th day of January, 1912, when the insured paid the interest for the year ending July 9, 1912. Nothing further was ever paid on either of the notes, and the insured died on the 7th day of June, 1912.

The policy in question was issued upon a written application signed by the insured and which, by its terms and the terms of the policy, became a part of the contract between defendant and the insured. This application contained the following provisions:

"That if any premiums of said insurance shall not be paid when due, all previous payments shall be forfeited to the company, except as provided in its policy. That if any note or other obligation is taken for any premium or part thereof, such note or other obligation shall not be payment thereof, but only the extension of time of payment of the same, and the failure to pay such note

or other obligation at maturity shall work a forfeiture of all previous payments, except as provided in the policy. * * * And that a failure to pay any premium or obligation given to the company therefor at the time the same becomes due * * * shall render any policy issued upon this application void and terminate all liability to the company thereon, except as provided in the said policy."

It will be remembered that the premium note given on the 26th day of January, 1912, was payable on the 1st day of June, 1912, and it is the contention of defendant that because said note was not paid on that date, and because the acceptance of said note was merely an extension of the time for the payment of the premium, the policy became forfeited on that date without any further act on the part of the defendant, and that all liability on said policy terminated on that date. On the other hand, it is contended by plaintiff that defendant waived its right of forfeiture, and that the policy was in force at the time of the insured's death, on the 7th day of June, 1912.

[1, 2] The conditions in the contract that provided for the immediate forfeiture of the policy upon the failure to pay the premium, being conditions in favor of the defendant, could be waived by it; and respondent bases its contention that such waiver took place upon the following circumstances: On the 7th day of June, 1912 (the day on which the death of the insured occurred), the defendant mailed the following letter addressed to the insured:—

"Dear Sir: Your policy loan held by this company, amounting to \$230, is due July 9th. This loan may be continued for another year by the payment of \$11.50 interest. Thanking you for your prompt attention to this matter, I remain, Very truly yours, F. L. Bramble, Secretary."

Again, on the 12th day of July, 1912, defendant mailed to the address of the insured the following notice:—

"Take Notice: Your regular fifth annual premium on policy No. 1360, amounting to \$5,000, will be due June 10, 1912. * * * F. L. Bramble, Secretary-Treasurer."

"Note.—Premiums are payable to the company, at its office in Watertown, S. D., and no payment of the same shall be valid if paid to an agent or any other person whatsoever, unless such person is possessed of and turns over to the payor a receipt signed by the president or secretary, countersigned by himself, as evidence of payment to him. According to the policy contract, policyholders must pay their premiums on or before the day upon which they fall due. And in the event of their failure to do so their policy of insurance shall be deemed forfeited and of no effect, except otherwise expressly stipulated in the policy."

On the 10th day of July, 1912, defendant mailed to the address of the insured the following letter:—

"Frank Hall, Conde, S. D.—Dear Sir: Your thirty days of

grace expire to-day. Only a very prompt remittance will save your policy from lapsing and save you the necessity of another medical examination before being reinstated. Kindly consider for a moment the three following facts: First. You have an excellent policy, and have money invested. A lapsed policy is money lost. Second. By paying this premium, you renew the protection given your family. By lapsing you subject them to the possibility of want in the event of your death. Third. Should you lapse your policy, you have no assurance that you would be able to pass a medical examination for reinstatement in this or any other company. If there is anything you do not understand about your policy, we will be glad to explain it to you. We would ask that before dropping the same, you give this matter your serious consideration. Hoping to hear from you at an early date as to your decision in the matter, I am, Yours very truly, F. L. Bramble, Secretary."

From these various communications, it is clearly apparent that, up to a time subsequent to the death of the insured, the defendant considered this policy in full force and effect. This could scarcely be made plainer than by the language used in the letter of July 10th. This letter was intended to inform the insured, not only that the policy was in full force during the thirty days of grace provided for in the policy, but that he might, by prompt action, prevent the policy from lapsing even after the expiration of said thirty days of grace.

What constitutes a waiver of a forfeiture clause in an insurance contract was recently discussed at some length by this court in the case of Noem vs. Life Ins. Co., 157 N. W. 308, and a review of the matter at this time would add nothing to what is said in that case. We are satisfied with the rule recognized in that case and the cases therein cited, and, applying that rule to this case, we find an abundance of facts to warrant the conclusion that the defendant waived the forfeiture clause found in its contract with the insured, and that the plaintiff is entitled to recover.

The judgment and order appealed from are affirmed.

SECURITY LIFE INS. CO. *vs.* MCCRAY. (No. 27.)*
(Supreme Court of Arkansas.)

1. INSURANCE—CONTRACT WITH AGENT—CONSTRUCTION.
The parties to a contract of agency for the sale of insurance had the right to agree upon its terms, and their rights are determined by its provisions, the whole contract and all of its terms being considered in arriving at their intention, each provision being given full effect so far as the language of the whole instrument will permit.

(For other cases, see Insurance, Cent. Dig. §§ 99, 100; Dec. Dig. § 74.)

* Decision rendered, May 29, 1916. 186 S. W. Rep. 819.

2. INSURANCE — AGENTS — CONTRACT — CONSTRUCTION — TERMINATION—COMMISSIONS.

Where a contract of agency for the sale of insurance, providing for payment of commissions and renewal commissions as long as the contract was in force, was terminated by act of the parties in accordance with its provisions, the agent was not entitled to commissions on renewal premiums received after the date of the termination of his agency, notwithstanding a provision in the contract that, if company was refused permission or ceased to do business in the state, the agent would be protected in rights acquired to renewal commissions.

(For other cases, see Insurance, Cent. Dig. § 112; Dec. Dig. § 84[4].)

Appeal from Circuit Court, Yell County; M. L. Davis, Judge.

Suit by A. S. McCray against the Security Life Insurance Company. Judgment for plaintiff, and defendant appeals. Reversed and dismissed.

A. S. McCray brought this suit for the collection of certain renewal commissions alleged to be due him under the terms of his agency contract for writing insurance for appellant company. It is admitted that the written contract was terminated on the 20th day of November, 1914, in accordance with its terms and all commissions and renewals paid to that time; the suit being brought for commissions for renewals from said 20th day of November, 1914, the date of the cancellation of the contract.

Section 3a of the contract provides:—

"The company, in consideration of the services to be rendered by the agent, agrees to pay the agent, as long as this contract is in force, on all business written by him, a commission upon the first year's premium of each policy accepted and paid for in cash, and a renewal commission upon subsequent premiums, when paid in cash in accordance with the following tables," which show the commissions to be 5 per cent on all except three kinds of policies designated, and "an additional renewal commission of 2 per cent for five years will be paid on premiums of policies written on the first three plans scheduled above."

Section 18 of the contract stipulates:—

"It is agreed that the provisions of this contract may be modified and changed without the consent of the agent if the same shall conflict with any state laws or rulings of any state insurance department; and, should the license of the company to do business in the resident state of the agent, or any other state in this contract, at any time be withheld or revoked, or the company for any cause cease to do business in said state, this contract shall immediately terminate, except as to any rights the agent may have acquired as to renewal commissions."

Appellee testified that he was entitled under the terms of the contract, notwithstanding the termination of it, to the \$130 claimed as renewal commissions, and recovered judgment therefor, from which this appeal is prosecuted.

J. T. Bullock, of Russellville, and Bradshaw, Rhoton & Helm, of Little Rock, for Appellant.

John B. Crownover, of Dardanelle, for Appellee.

MISSOURI STATE LIFE INS. CO. *vs.* CRABTREE.

(No. 33.)*

(Supreme Court of Arkansas.)

1. INSURANCE—LIFE INSURANCE—OPTIONS—NOTICE.

A life policy provided that, in event of nonpayment after payment of two premiums, the policy should be continued as term insurance for such a period as the surrender value would purchase term insurance. A note given by insured for the payment of the third premium declared that, in event of nonpayment, the insured should be personally liable for a sum equal to one-half of the principal, but that the insurer should have an option to treat such liability as indebtedness on account of the policy reducing the surrender value. *Held*, that the insurer was bound to give notice of its option to treat the indebtedness evidenced by the note as indebtedness against the policy, and, having retained the note without notice, could not deduct one-half of the amount thereof from the surrender value of the policy so as to reduce the period of term insurance.

(For other cases, see Insurance, Cent. Dig. § 934; Dec. Dig. § 366.)

2. INSURANCE—LIFE INSURANCE—RIGHTS OF BENEFICIARY.

An insurer cannot by contract with the insured change the vested rights of the beneficiary.

(For other cases, see Insurance, Cent. Dig. § 1470; Dec. Dig. § 586.)

Appeal from Circuit Court, Greene County; W. J. Driver, Judge.

Action by Mary M. Crabtree against the Missouri State Life Insurance Company. From a judgment for plaintiff, defendant appeals. Affirmed.

Jones, Hocker, Sullivan & Angert, of St. Louis, Mo., and Block & Kirsch, of Paragould, for Appellant.

M. P. Huddleston, Robert E. Fuhr, and J. M. Futrell, all of Paragould, for Appellee.

* Decision rendered, June 5, 1916. 187 S. W. Rep. 173.



EMINENT HOUSEHOLD OF COLUMBIAN WOODMEN

(No. 35.)*

(Supreme Court of Arkansas.)

3. INSURANCE — FRATERNAL INSURANCE — DEATH WHILE VIOLATING LAW—INTOXICATION.

Where the by-laws of a fraternal insurance association barred recovery if the insured should meet his death while in violation of law and the insured was killed when assaulting a marshal, his voluntary intoxication was not, under Kirby's Dig. § 1557, declaring that voluntary

* Decision rendered, June 5, 1916. 187 S. W. Rep. 176.

intoxication is no excuse for crime, any excuse, and an instruction so declaring the law was improperly refused.

(For other cases, see Insurance, Cent. Dig. §§ 1955, 1957-1959; Dec. Dig. § 787.)

Appeal from Circuit Court, White County; J. M. Jackson, Judge.
Action by Laura O. Howle against the Eminent Household of Columbian Woodmen. From a judgment for plaintiff, defendant appeals. Reversed and remanded.

Plaintiff's instruction No. 9 is as follows:—

The jury is instructed that, if you find from the evidence that at the time the deceased, Howle, made the assault upon the marshal, Sowell, he knew right from wrong, and he knew it was wrong to make said assault, then, under the law, he was sane, unless you find that at the time he was acting under an irresistible impulse arising from a defect in his will caused by the diseased condition of his mind, and was not acting from mere anger or revenge.

Brundidge & Neelly, of Searcy, for Appellant.

Rachels & Yarnell and Jno. E. Miller, all of Searcy, for Appellee.



WILKES ET AL VS. HICKS. (No. 25).*

(Supreme Court of Arkansas.)

1. INSURANCE—BENEFIT ASSOCIATIONS—CHANGE OF BENEFICIARY.

Where the by-laws of a benefit society authorize a change of beneficiary at any time, a member's right to change the beneficiary is absolute and can be made at any time upon substantial compliance with the by-laws.

(For other cases, see Insurance, Cent. Dig. § 1946; Dec. Dig. § 780.)

2. INSURANCE—BENEFIT ASSOCIATIONS—RIGHTS OF BENEFICIARY.

Under the by-laws of a benefit society allowing a member to change the beneficiary in his policy at any time but providing that the change should not take effect until furnished to the officer named and inserted by him in the policy, where the insured wrote a request for a change of beneficiary in the presence of members of the order and directed it to be forwarded to the officer authorized to make the change but died before it was sent, the request being forwarded with proofs of his death, the right of the beneficiary named in the policy to the proceeds of the policy became vested and could not be defeated by the claim of the person named in the request.

(For other cases, see Insurance, Cent. Dig. § 1951; Dec. Dig. § 784[2].)

Appeal from Pulaski Chancery Court; John E. Martineau, Chancellor. Interpleader by the Knights of Pythias of North America against George Hicks and Carter Wilkes and others. From a decree for defendant

* Decision rendered, May 29, 1916. 186 S. W. Rep. 830.

George Hicks, defendants Carter Wilkes and others appeal. Reversed and remanded, with directions.

Carmichael, Brooks, Powers & Rector, of Little Rock, for Appellants.
Bradshaw, Rhoton & Helm, of Little Rock, for Appellee.

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LINNEWEBER ET AL. VS. SUPREME COUNCIL CATHOLIC KNIGHTS OF AMERICA. (Civ. 1823.)*

(District Court of Appeal of California. First District.)

1. INSURANCE—WHAT PROVISIONS GOVERN—AMENDMENT.

A provision in a benefit certificate relating to the presumption of the death from unexplained absence would govern as it read at the time of the insured's disappearance, which the court found to have been the date of his death, and not as subsequently amended.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[1].)

4. INSURANCE—FRATERNAL INSURANCE—DEATH—SUFFICIENCY OF EVIDENCE.

Evidence, in an action on a benefit certificate, held sufficient to sustain a finding fixing the date of insured's death, after the presumption of death from unexplained absence had sufficed to prove the fact of his death.

(For other cases, see Insurance, Cent. Dig. § 2002; Dec. Dig. § 817[4].)

5. INSURANCE—FRATERNAL INSURANCE—SUSPENSION.

A member could not be lawfully suspended from a beneficiary association for nonpayment of dues at any time after the day on which he was found to have died, and, upon proof of death and the date thereof, the beneficiaries would not be bound to keep such dues paid to preserve their right to receive the benefits accruing by virtue of the insured's membership at the time of his death.

(For other cases, see Insurance, Cent. Dig. §§ 1895, 1896, 1903; Dec. Dig. § 750.)

7. INSURANCE—FRATERNAL INSURANCE—RECOVERY.

Where, so far as the records show, the plaintiffs, children of the original beneficiary, were the real and only parties at interest, they were entitled to maintain an action on the certificate, in the absence of the affirmative pleading and proof to the contrary.

(For other cases, see Insurance, Cent. Dig. § 1994; Dec. Dig. § 813.)

Appeal from Superior Court, City and County of San Francisco; Jas. M. Troutt, Judge.

Action by Mary Linneweber and others against Supreme Council Catholic Knights of America. Judgment for defendant, motion for new trial denied, and plaintiffs appeal. Judgment and order reversed.

* Decision rendered, April 27, 1916. Rehearing denied by Supreme Court, June 26, 1916. 158 Pac. Rep. 229.

F. W. Von Schrader and Von Schrader & Cadwalader, all of San Francisco, for Appellants.

Walter Christie and F. J. Kierce, both of San Francisco, for Respondent.



**KNIGHTS AND LADIES OF SECURITY vs. CONSIDINE
ET UX. (No. 8639.)***
(Supreme Court of Colorado.)

1. INSURANCE—LIFE INSURANCE—BREACH OF WARRANTY.

Where an applicant for membership in a fraternal order falsely stated in his application that he was not afflicted with disease, had not been treated by a physician and surgeon within five years, and had not undergone any surgical operation, etc., which answers and statements were warranted by him to be true by the terms of the application, his beneficiaries were not entitled to recover for his death on the certificate issued to him.

(For other cases, see Insurance, Cent. Dig. § 1863; Dec. Dig. § 723[5].)

2. INSURANCE—LIFE INSURANCE—FAILURE TO READ APPLICATION—EFFECT.

Where an applicant for membership in a fraternal benefit order did not ask to read his application and answers before or after he signed it, and was not prevented from so doing, his failure to read it did not void the consequences of his false statements in the application relative to his bodily condition, made warranties by the terms of the application

(For other cases, see Insurance, Cent. Dig. § 1863; Dec. Dig. § 723[5].)

Error to District Court, Lake County; Charles Cavender, Judge.

Action by James Considine and wife against the Knights and Ladies of Security. To review a judgment for plaintiffs, defendant brings error. Judgment reversed, with instruction to enter judgment for defendant.

John A. Ewing and Michael F. Ryan, both of Leadville, for Plaintiff in Error.

Hogan & Bonner, of Leadville, for Defendants in Error.

* Decision rendered, May 1, 1916. Rehearing denied, July 3, 1916. 158 Pac. Rep. 282.

APITZ vs. SUPREME LODGE KNIGHTS & LADIES OF HONOR. (No. 10598.)*

(Supreme Court of Illinois.)

3. INSURANCE—FRATERNAL—BY-LAWS—CHANGE.

By-laws of a fraternal benefit association apply to a benefit certificate issued before their enactment, it reserving the right to the association to amend or change by-laws, and containing agreement of the member to be bound thereby.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[1].)

4. INSURANCE—FRATERNAL—BY-LAWS — REASONABLENESS.

A by-law of a fraternal benefit association that a member shall stand suspended after disappearance for a year is not unreasonable as to a certificate issued before its enactment, authorizing changes in by-laws.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[1].)

Appeal from Appellate Court, Second District, on Appeal from Circuit Court, Winnebago County, Arthur H. Frost, Judge.

Action by Lizzie Apitz against the Supreme Lodge Knights and Ladies of Honor. Judgment for plaintiff was reversed by the Appellate Court, and she brings error. Affirmed.

Roy F. Hall, of Rockford, for Plaintiff in Error.

Carpenter & St. John, of Rockford, and Ashcraft & Ashcraft, of Chicago (Edwin M. Ashcraft, of Chicago, of counsel), for Defendant in Error.

* Decision rendered, June 22, 1916. 113 N. E. Rep. 63.

**WATSON vs. MUTUAL LIFE INS. CO. OF NEW YORK.**

(No. 20561.)*

(Supreme Court of Louisiana.)

INSURANCE—LIMITATION OF ACTIONS—PRESCRIPTION — ACTIONS—LIMITATIONS.

Where by its twenty-year payment life policy a mutual life insurance company agrees to pay the amount therein called for to the named beneficiary at the death of the assured, upon the "condition" that the annual premiums are paid in advance for twenty years, and subject to the "provision, requirement, or benefit" that, after three full annual premiums have been paid upon the policy, the company will, upon the legal surrender thereof, before default in payment of any premium, or within six months thereafter, issue a nonparticipating policy for paid-up insurance, payable as herein provided, for the proportion of

* Decision rendered, June 5, 1916. 72 South. Rep. 189. Syllabus by the Court.

the amount of this policy which the number of full years' premiums paid bears to the total number required," and where, after paying six premiums, the assured defaults in the payment of the seventh and subsequent premiums, and three years later is informed that his policy has lapsed, but that he may have it restored on complying with certain requirements, and where for eleven years following the receipt of that information, and up to the time of his death, the assured takes no further steps in the matter, and his heir takes none for more than three years after his death, the suit of the latter, then instituted, as upon a paid-up policy, for six-twentieths of the amount called for by the policy originally issued, is barred by the prescription of ten years established against personal actions by Civ. Code, art. 3544, and by the prescription of two years established by Act 68 of 1906 against actions to recover under forfeited policies.

(For other cases, see Insurance, Cent. Dig. §§ 1540, 1544; Dec. Dig. § 622[1]. Limitation of Actions, Cent. Dig. §§ 190, 191; Dec. Dig. § 39[1].)

Appeal from Eleventh Judicial District Court, Parish of Natchitoches; Wm. T. Cunningham, Judge.

Action by Mrs. A. W. Watson against the Mutual Life Insurance Company of New York. From a judgment for defendant. plaintiff appeals. Affirmed.

Henry & Gunter, of Natchitoches, for Appellant.

Denegre, Leovy & Chaffe, of New Orleans, and Scarborough & Carver, of Natchitoches, for Appellee.



ROYAL ARCANUM *vs.* VITZTHUM. No. 52.)*

(Court of Appeals of Maryland.)

2. INSURANCE—FRATERNAL BENEFIT INSURANCE—REASONABLENESS OF BY-LAW.

In determining whether a by-law of a fraternal benefit association enacted after a member joined the order is reasonable, reference should be had to the nature and purpose of the contract, read in the light of the objects of the order.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[1].)

3. INSURANCE—FRATERNAL BENEFIT INSURANCE—BY-LAW—REASONABLENESS.

The by-law of a fraternal benefit insurance association suspending a member who has disappeared, if he cannot be located, from the time when the first effort is made by the order to do so, if he does not make known his whereabouts within six months, etc., made after the member joined the order, is reasonable and enforceable against the beneficiary of the member who agreed with the order when he was admitted that, should he voluntarily sever his connection with it, his act should forfeit

* Decision rendered, May 17, 1916. 97 Atl. Rep. 923.

his own rights, and those of his family and dependents, to all benefits and privileges of the order.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[1].)

Appeal from Superior Court of Baltimore City; Morris A Soper, Judge.

"To be officially reported."

Action by Louisa C. Vitzthum against the Royal Arcanum, a corporation. From a judgment for plaintiff, defendant appeals. Judgment reversed without new trial.

Argued before Boyd, C. J., and Burke, Thomas, Pattison, Urner, and Stockbridge, JJ.

Andrew C. Tippe, of Baltimore (J. McC. Tippe, of Baltimore, on the brief), for Appellant.

Samuel Want, of Baltimore, for Appellee.



McCARTY vs. CAVANAUGH ET AL.*

(Supreme Judicial Court of Massachusetts. Middlesex.)

1. INSURANCE—FRATERNAL BENEFIT INSURANCE—"CHARITABLE ORGANIZATION."

A fraternal beneficiary association is not a "charitable organization."

(For other cases, see Insurance, Cent. Dig. § 1824; Dec. Dig. § 687.)

(For other definitions, see Words and Phrases, First and Second Series, Charity.)

2. INSURANCE — FRATERNAL BENEFIT INSURANCE — RIGHT OF LODGES—"DISBAND."

Evidence held to show that a local benefit lodge "seceded" and did not "disband," where the entire membership withdrew, so as not to require payment to the Grand Lodge of the local funds as required in case of disbanding.

(For other cases, see Insurance, Cent. Dig. § 1838; Dec. Dig. § 697.)

(For other definitions, see Words and Phrases, Disband.)

3. INSURANCE — FRATERNAL BENEFIT INSURANCE — RIGHT OF LODGES.

In the absence of charter or constitutional provision to the contrary, a local lodge of a fraternal benefit association has the right to secede from the Grand Lodge without forfeiting its funds.

(For other cases, see Insurance, Cent. Dig. § 1838; Dec. Dig. § 697.)

Appeal from Superior Court, Middlesex County.

Action by Julia A. McCarty against Mary Cavanaugh and others. From an interlocutory decree modifying and confirming the master's report and final decree dismissing the bill, plaintiff appeals. Affirmed.

* Decision rendered, June 21, 1916. 113 N. E. Rep. 271.

Elias Field and Brown, Field & Murray, all of Boston, for Plaintiff.
John J. Shaughnessy, of Marlboro, and John M. Maloney, of Boston,
for Respondents.

RUANE vs. MANHATTAN LIFE INS. CO. (No. 1687.)*
(Springfield Court of Appeals. Missouri.)

1. INSURANCE—"RESERVE FUND."

The equitable value of a life insurance policy constitutes its "reserve fund."
(For other cases, see Insurance, Cent. Dig. § 931; Dec. Dig. § 364.)
(For other definitions, see Words and Phrases, First and Second Series,
Reserve Fund.)

2. INSURANCE—LOAN AGREEMENT—CONSTRUCTION.

A provision in a loan agreement between an insurer and the insured that
on the death of the insured the amount due on the obligation should
be deducted from the amount of the policy meant that, if the insured
died when the policy was in force and his indebtedness was unpaid,
it should be deducted from the amount payable under the policy.

(For other cases, see Insurance, Dec. Dig. § 179½.)

3. INSURANCE — LAPSE — EXTENDED INSURANCE — DEDUCTION OF LOAN.

A life insurance policy provided that, when it ceased or became void, all
previous payments should be forfeited to the company, except that,
in case of forfeiture after three or more years' premiums had been
paid, the company would purchase the policy at its equitable value, to
be determined by it, and a loan agreement provided that on the death
of the insured the amount due on the obligation would be deducted
from the amount of the policy, and after the payment of premiums for
more than three years and lapse of the policy for default in premiums,
and when the insured was indebted to the insurer on a loan, the in-
surer calculated the reserve and deducted from three-fourths thereof
the amount due on the loan and applied the balance as a net single
premium to the purchase of extended insurance for a period which
had expired before the death of the insured. *Held* that, although the
insurer applied so much of the statute, then in force, but not binding on
it, as authorized the deduction of one-fourth of the reserve it was not
bound to apply the other part of the statute, forbidding the deduction
of such loan from the reserve before three-fourths of the reserve was
applied to the purchase of extended insurance.

(For other cases, see Insurance, Cent. Dig. § 938; Dec. Dig. § 367[2].)

5. INSURANCE—RESERVE VALUE—LOAN AGREEMENT—SETTLEMENT.

A provision in a loan agreement that upon default the pledge of the policy
should be foreclosed by satisfying the indebtedness out of its reserve,
and the balance, if any, paid to the insured in cash or applied to pur-

* Decision rendered, May 25, 1916. Rehearing denied, June 24, 1916.
186 S. W. Rep. 1188.

chase extended insurance, is a reasonable and practicable method of settling the contract, not inconsistent with sound public policy, or violative of the constitutional rights of the insured.
(For other cases, see Insurance, Dec. Dig. § 179½.)

6. INSURANCE—LIFE INSURANCE—INSURER AS TRUSTEE.
An insurer is held as a trustee to fairly and properly treat the assured.
(For other cases, see Insurance, Cent. Dig. §§ 172, 178; Dec. Dig. § 124.)

Appeal from Circuit Court, Wayne County; E. M. Dearing, Judge.
Action by Charles I. Ruane, administrator of the estate of James Ruane, deceased, against the Manhattan Life Insurance Company. Judgment for plaintiff, and defendant appeals. Reversed.

Jones, Hocker, Sullivan & Angert and James C. Jones, Jr., all of St. Louis, for Appellant.
Charles P. Damron, of Newport, Ark., and Anderson, Gilbert & Levi, of St. Louis, for Respondent.

STURGEON vs. PIONEER LIFE INS. CO. (No. 12085).*
(Kansas City Court of Appeals. Missouri.)

1. INSURANCE — LIFE INSURANCE — MEDICAL EXAMINER — STATUTE.

A life insurance company could not have complied with Rev. St. 1909, § 6975, forbidding the issuance of a policy to any person until the applicant has been examined by a physician duly licensed and appointed by the company as its medical examiner, by employing an examiner in Missouri who had not been licensed to practice medicine therein pursuant to Rev. St. 1909, §§ 8311-8319.

(For other cases, see Insurance, Cent. Dig. § 195; Dec. Dig. § 130[1].)

Appeal from Circuit Court, Jackson County; C. A. Burney, Judge.
"Not to be officially published."
Action by Q. A. Sturgeon against the Pioneer Life Insurance Company. From a judgment for plaintiff, defendant appeals. Judgment reversed, and cause remanded.

Albert L. Reeves, of Kansas City, for Appellant.
E. H. Busiek and Paul R. Stinson, both of Kansas City, for Respondent.

* Decision rendered, June 12, 1916. 186 S. W. Rep. 1192.

BOWMAN VS. ANDERSON ET AL. (No. 17229.)*

(Supreme Court of Missouri. Division No. 2.)

1. INSURANCE—CONSOLIDATION—LIABILITY OF DIRECTORS FOR UNAUTHORIZED CONSOLIDATION.

Evidence *held* sufficient to show that directors of fraternal life insurance society did not act in good faith in assigning all assets and business of the society to an "old-line" insurance company so as to be relieved of individual liability for such unauthorized transaction.

(For other cases, see Insurance, Cent. Dig. § 1836; Dec. Dig. § 695.)

3. INSURANCE—CONSOLIDATION—LIABILITY OF DIRECTORS FOR UNAUTHORIZED DISPOSITION OF ASSETS.

Where directors of a fraternal life insurance society attempted an unauthorized consolidation with another company whereby all the assets of the fraternity were assigned, they are not liable to the receiver of the fraternal society for the amount of such assets as are actually applied by the assignee to the payment of the valid obligations of the fraternal society.

(For other cases, see Insurance, Cent. Dig. § 1836; Dec. Dig. § 695.)

4. INSURANCE—BY-LAWS—REQUIREMENTS AS TO PROOF OF DEATH AND ALLOWANCE OF CLAIMS.

Under by-laws of a fraternal insurance society requiring proof of death and allowance of claims by board of directors, a recovery on a policy may be had without approval of board of directors.

(For other cases, see Insurance, Deg. Dig. § 804.)

5. INSURANCE—CONSOLIDATION—LIABILITY OF DIRECTORS FOR UNAUTHORIZED DISPOSITION OF ASSETS.

Where directors of fraternal life insurance society in an unauthorized attempt at consolidation assigned all assets of the society to another company, the payment by the latter of a death claim against such fraternal society, although such claim was not allowed by the board of directors of the society, *held* proper, and the directors were not liable to the society for the assets used in paying such claim.

(For other cases, see Insurance, Cent. Dig. § 1836; Dec. Dig. § 695.)

6. INSURANCE—ACTIONS—EVIDENCE—PROOFS OF DEATH.

Proofs of death in an action involving recovery on life insurance policies are competent to prove that such proofs were made, but incompetent to prove the facts therein stated.

(For other cases, see Insurance, Cent. Dig. § 2003; Dec. Dig. § 818[4].)

8. INSURANCE — ACTIONS AGAINST OFFICERS — ANSWER — SUFFICIENCY.

In an action against directors of a fraternal insurance society for wrongful assignment of assets, an answer alleging in general terms payment of valid claims out of such assets is sufficient to support proof of particular claims, where no motion is made by plaintiff to make such answer more specific.

(For other cases, see Insurance, Cent. Dig. § 1836; Dec. Dig. § 695.)

* Decision rendered, March 31, 1916. Rehearing denied, May 31, 1916.
186 S. W. Rep. 1012.

9. INSURANCE—FRATERNAL SOCIETY—DISTRIBUTION OF ASSETS.

In an action against directors of a fraternal insurance society for assets wrongfully assigned, in an attempted consolidation an answer alleging that a large number of the members of the fraternity accepted the contract of the consolidated company, but not alleging the ages of such members, the amounts of their policies, or the amount of assessments paid by them, does not show facts from which the proportion of assets of the fraternal society to which they were entitled could be determined.

(For other cases, see Insurance, Cent. Dig. § 1836; Dec. Dig. § 695.)

10. INSURANCE—FRATERNAL LIFE INSURANCE SOCIETY—ASSETS—OWNERSHIP.

The assets of a fraternal life insurance society belong to the organization composed of persevering or surviving members.

(For other cases, see Insurance, Cent. Dig. § 1834; Dec. Dig. § 694[1].)

Appeal from Circuit Court, Buchanan County; L. J. Eastin, Judge.
Action by Frank L. Bowman, receiver, against William W. Anderson and others. Judgment for plaintiff, and defendants appeal. Reversed and remanded, with directions.

Ed. E. Yates, of Kansas City, W. M. Williams, of Booneville, and Perry S. Rader, of Jefferson City, for Appellants.

D. E. Adams, of Hamilton, and W. M. Fitch, of St. Louis, for Respondent.

**BUSH vs. BLOCK ET AL. (No. 12026.)***

(Kansas City Court of Appeals. Missouri.)

3. INSURANCE—LIFE POLICY—RIGHT OF ASSIGNEE.

The assignee of a life insurance policy taken as security for the insured's note had the right, upon insured's refusal to pay further premiums, to convert the policy into a paid-up policy, upon notice to the insured.
(For other cases, see Insurance, Cent. Dig. § 492; Dec. Dig. § 222.)

4. INSURANCE—ASSIGNMENT OF LIFE POLICY—OBLIGATION TO PAY PREMIUMS.

The assignment of a life insurance policy as security for a note did not relieve the insured of the obligation to pay premiums.

(For other cases, see Insurance, Cent. Dig. § 492; Dec. Dig. § 222.)

5. INSURANCE—NECESSARY PARTY—STATUTE.

Under Rev. St. 1909, § 1732, providing that any person who has or claims an interest in a controversy adverse to the plaintiff, or who is a necessary party to a complete determination or settlement of the question involved, may be made a defendant, in suit by an assignee of judgment on a note to foreclose insured's interest in a life policy assigned by him as security for the note, which policy, upon insured's

* Decision rendered, June 12, 1916. 187 S. W. Rep. 153.

failure to pay premiums, the holder of the note converted into a paid-up policy, the insurance company, not claiming an interest, was not a necessary party.

(For other cases, see Insurance, Cent. Dig. § 492; Dec. Dig. § 222.)

Appeal from Circuit Court, Jackson County; E. E. Porterfield, Judge.
"To be officially published."

Suit by Charles M. Bush against Maurice Block and another. From a judgment for plaintiff, defendants appeal. Affirmed.

F. Titus and S. A. Dew, both of Kansas City, for Appellants.
R. W. Crimm and Chas. M. Bush, both of Kansas City, for Respondent.



TUITE *vs.* SUPREME FOREST WOODMEN CIRCLE.

(No. 12030.)*

(Kansas City Court of Appeals. Missouri.)

1. INSURANCE — FRATERNAL BENEFICIARY INSURANCE — BENEFICIARIES — WHAT LAW GOVERNS.

Under Rev. St. 1909, § 7190, providing for the payment of death benefits to the families, heirs, blood relatives, or persons dependent upon the member, and in view of Rev. St. 1909, §§ 1671-1678, making an adopted child the heir of the adopting parent, a foreign fraternal beneficiary society licensed to do business in the state and to issue to beneficiaries, certificates including the "adopted children * * * or other relatives," the term "other relatives," appearing by the context to refer to blood relatives, would be accorded the benefit of the laws of this state relating to such insurance, as there was no substantial difference between the classes of beneficiaries.

(For other cases, see Insurance, Cent. Dig. §§ 173-175, 293, 1934; Dec. Dig. § 712.)

2. INSURANCE — FRATERNAL INSURANCE — CONTRACT — ULTRA VIRES — WAIVER.

A fraternal beneficiary association, chartered by a state whose laws forbade the issuance of a death benefit certificate to any one over fifty-five years of age, and whose charter fixed the maximum rate at fifty-two, and which on investigation after the death of a member and its conviction that he had intentionally misrepresented his age as fifty instead of sixty or sixty-one years, could not waive or estop itself from setting up the defense that the certificate was ultra vires and void, as the association could not be bound by waiver or estoppel to a contract which its charter would not authorize.

(For other cases, see Insurance, Cent. Dig. §§ 1837, 1866, 1868; Dec. Dig. § 724[1].)

* Decision rendered, June 12, 1916. 187 S. W. Rep. 137.

3. INSURANCE — FRATERNAL INSURANCE — CONTRACT — ULTRA VIRES—REMEDY OF INSURER.

If the insured was older than the maximum age at the time he applied for his certificate and membership, the only remedy which his beneficiary might enforce against the insurer would be to recover back the money insured had paid for insurance.

(For other cases, see Insurance, Cent. Dig. § 1888; Dec. Dig. § 743.)

4. INSURANCE — FRATERNAL INSURANCE — INTEREST OF BENEFICIARY.

The interest of a beneficiary in a certificate before the death of the insured, is only an expectancy, and not a vested interest.

(For other cases, see Insurance, Cent. Dig. § 1949; Dec. Dig. § 783.)

6. INSURANCE — LIFE INSURANCE — INTEREST OF BENEFICIARY.

Where a contract is one of ordinary life insurance, the beneficiary acquires a vested interest therein from the date of the contract.

(For other cases, see Insurance, Cent. Dig. § 1470; Dec. Dig. § 586.)

11. INSURANCE—FRATERNAL INSURANCE—RIGHTS OF INSURED—RECOVERY OF PREMIUM—TENDER.

In an action on a fraternal beneficiary certificate, where the insurer if sustaining the defense of ultra vires would be liable for the premiums received of the insured as for money had and received, it was not bound to make a sufficient tender or any tender on pain of waiving its rights to defend on the ground of ultra vires.

(For other cases, see Insurance, Cent. Dig. §§ 1837, 1866, 1868; Dec. Dig. § 724[1].)

Appeal from Circuit Court, Jackson County; Frank G. Johnson, Judge. Action by Mrs. C. E. Tuite against Supreme Forest Woodmen Circle. Judgment for plaintiff, and, from an order setting aside the verdict and ordering a new trial, plaintiff appeals. Affirmed.

Noyes & Heath, of Kansas City, for Appellant.
Harding, Murphy & Harris, of Kansas City, for Respondent.

**NATIONAL CIRCLE, DAUGHTERS OF ISABELLA, vs.
NATIONAL ORDER OF THE DAUGHTERS
OF ISABELLA.***

(U. S. District Court. N. D. New York.)

2. INSURANCE—FRATERNAL ORDERS—INCORPORATION.

A fraternal order incorporated under the laws of New York, whose business was the installation of subordinate branches, is entitled to establish such branches outside of the state, even in the absence of express or explicit authority.

(For other cases, see Insurance, Cent. Dig. § 1832; Dec. Dig. § 692.)

* Decision rendered, May 19, 1916. 232 Fed. Rep. 907.

In Equity. Bill by the National Circle, Daughters of Isabella, against the National Order of the Daughters of Isabella. An application by complainant for an injunction pendente lite. Application denied.

Mills & Mills, of Albany, N. Y. (C. F. Roberts, of New Haven, Conn., of counsel), for Complainant.

P. H. Fitzgerald, of Utica, N. Y. (Richard R. Martin, of Utica, N. Y., of counsel), for Defendant.



WANERKA vs. SUPREME COUNCIL OF THE ROYAL ARCANUM.*

(New York Supreme Court, Appellate Term, First Department.)

1. INSURANCE—MUTUAL BENEFIT INSURANCE—BREACH OF WARRANTY—BURDEN OF PROOF.

In a widow's action to recover on a certificate of mutual benefit insurance, the burden was on the insurer to prove breach of warranty by insured that he had never applied for insurance in any life insurance company and been rejected.

(For other cases, see Insurance, Cent. Dig. § 2001; Dec. Dig. § 817[2].)

2. INSURANCE—MUTUAL BENEFIT INSURANCE—QUESTION FOR JURY.

In a widow's action to recover an amount of insurance payable under the certificate of a mutual benefit association, question whether insured had applied for insurance in a life insurance company and made answers relative thereto, as claimed, in his application for membership in defendant society, held for the jury under the evidence.

(For other cases, see Insurance, Cent. Dig. § 2009; Dec. Dig. § 825[2].)

Appeal from City Court of New York, Trial Term.

Action by Antonia Wanerka against the Supreme Council of the Royal Arcanum. From a judgment on verdict directed for defendant, plaintiff appeals. Judgment reversed, and new trial ordered.

Argued June term, 1916, before Guy, Bijur, and Philbin, JJ.

Morris & Samuel Meyers, of New York City, for Appellant.
Uriah W. Thompkins, of New York City, for Respondent.

* Decision rendered, June 21, 1916. 159 N. Y. Supp. 697.

**DEVIN ET AL. vs. CONNECTICUT MUT. LIFE INS. CO.
ET AL. (No. 6597.)***
(Supreme Court of Oklahoma.)

1. INSURANCE—ASSIGNMENT—DELIVERY OF POLICY—PRESUMPTION.

Where the evidence discloses that a life insurance policy which has been assigned in writing to the wife of the insured is in the possession of such wife, a presumption of the delivery of such assigned policy to the wife arises.

(For other cases, see Insurance, Cent. Dig. § 480; Dec. Dig. § 211.)

2. INSURANCE—ASSIGNMENT—EFFECT.

An unconditional assignment of a life insurance policy duly executed and delivered divests the insured of all right and title to said policy of insurance and vests the beneficial interest therein in the assignee.

(For other cases, see Insurance, Cent. Dig. § 483; Dec. Dig. § 213.)

3. INSURANCE—RIGHT TO PROCEEDS—EFFECT OF ASSIGNMENT.

Where an insured assigns his policy of life insurance to his wife and delivers said policy to the wife, the subsequent death of the wife does not operate to restore the title to the policy to the insured, and an alteration in said assignment by striking out the name of the first assignee and substituting therefor the words "my wife," made by the insured after the death of his wife, does not operate to transfer the title to the proceeds of said insurance policy to a second wife.

(For other cases, see Insurance, Cent. Dig. §§ 1452, 1476-1478, 1482, 1485; Dec. Dig. § 593[1].)

Commissioners' Opinion, Division No. 1. Error from District Court, Woods County; W. C. Crow, Judge.

Action by the Connecticut Mutual Life Insurance Company against Charley Devin and others. From a judgment in favor of the defendant Laura E. Devin, the defendant Charley Devin and others bring error. Reversed, with directions.

A. G. Sutton, of Alva, for Plaintiffs in Error.
E. W. Snoddy, of Alva, for Defendants in Error.

* Decision rendered, June 20, 1916. 158 Pac. Rep. 435. Syllabus by the Court.

—————
GRANT VS. FAIRES ET AL.*
(Supreme Court of Pennsylvania.)

1. INSURANCE — FRATERNAL BENEFIT INSURANCE — DISPOSITION OF PROCEEDS.

A fund arising on a death benefit certificate is not subject to the disposal of the holder of the certificate, testamentary or otherwise, except as

* Decision rendered, April 17, 1916. 97 Atl. Rep. 1060.

to his right of designation of beneficiary pursuant to the rules of the order.

(For other cases, see Insurance, Cent. Dig. §§ 1950-1952; Dec. Dig. § 784[1].)

2. INSURANCE—FRATERNAL BENEFIT INSURANCE—RIGHT TO PROCEEDS.

Under Act May 24, 1893 (P. L. 126), providing that, where the beneficiary named in a benefit certificate dies before the member, and there is no new designation and no provision in the laws of the society, the fund shall be payable to the member's widow and children, and, if none, to his other relatives as personal estate according to the laws of his domicile, where a beneficiary died before the member, the next of kin were entitled to the fund, notwithstanding an indorsement by the member on a letter relating to the fund expressing the desire that it should be paid to a person named who was not such a person as under the by-laws of the association was capable of being a beneficiary; the beneficiary not having been changed according to the by-laws of the association.

(For other cases, see Insurance, Cent. Dig. §§ 1943, 1974; Dec. Dig. § 785.)

3. INSURANCE—FRATERNAL BENEFIT INSURANCE—RIGHT TO PROCEEDS—WAIVER BY SOCIETY.

A fraternal society cannot after the death of a member waive the vested rights of the parties entitled to the death benefit by paying the fund to the member's executors as stakeholders pending the legal determination as to who is entitled thereto.

(For other cases, see Insurance, Cent. Dig. §§ 1967-1972, 1980; Dec. Dig. 793.)

Appeal from Court of Common Pleas, Philadelphia County.

Action by Pattie Faires Grant against James D. Faires, executor of the estate of William J. Faires, and others, to determine title to a fund accruing on a death benefit certificate. From a judgment for plaintiff, the executor and another appeal. Reversed and rendered.

Argued before Brown, C. J., and Mestrezat, Stewart, Frazer, and Walling, JJ.

Edward Hopkinson, Jr., and Dickson, Beitler & McCouch, all of Philadelphia, for Appellants.

George W. Harkins, Jr., and Herbert Simons, both of Philadelphia, for Appellee.



HARTFORD LIFE INS. CO. ET AL. VS. BENSON.

(No. 5592.)*

(Court of Civil Appeals of Texas. Austin.)

INSURANCE—POLICY LOAN AGREEMENT—VALIDITY.

In a paid-up life policy loan note, an agreement by insured and beneficiary that on nonpayment of the note the amount of paid-up insurance guar-

* Decision rendered, March 22, 1916. Rehearing denied, June 7, 1916. 187 S. W. Rep. 351.

anted in the policy should be reduced in the same proportion as the indebtedness bore to the cash surrender value is reasonable and valid and in harmony with the policy indicated by the Rev. St. 1911, art. 4741, requiring policies to stipulate that "the failure to repay any such advance or to pay interest shall not void the policy until the total indebtedness thereon to the company shall equal or exceed the loan value," although not providing for a sale of the policy pledged for nonpayment of the note, since there can be no general market for life insurance policies outside of relatives and creditors.

(For other cases, see *Insurances*, Dec. Dig. § 179½.)

Error from District Court, Tom Green County; J. W. Timmins, Judge.

Action by Mrs. Ora Benson against the Hartford Life Insurance Company and another. Judgment for plaintiff, and defendants bring error. Reversed and rendered in part, and in part reformed and affirmed.

Locke & Locke, of Dallas, for Plaintiffs in Error.
Hill, Lee & Hill, of San Angelo, and O. F. Wencker and E. S. Hamilton, both of Dallas, for Defendant in Error.



QUINN *vs.* MUTUAL LIFE INS. CO. OF NEW YORK.

(No. 13368.)*

(Supreme Court of Washington.)

2. INSURANCE—LIFE INSURANCE—AVOIDANCE FOR MISREPRESENTATION—STATUTE.

Under Insurance Code 1911, § 34, Laws 1911, p. 197, providing that no oral or written misrepresentation or warranty made in the negotiation of a contract or policy of insurance, by the assured or in his behalf, shall be deemed material or defeat or avoid the policy or prevent its attaching, unless such misrepresentation or warranty is made with the intent to deceive, it being presumed that one who makes a false representation with knowledge of its falsity does so with intent to deceive, where the deceased knowing that he had syphilis, and had been treated by a physician within two months, his statements in his application for the policy that he had had no diseases since childhood, and had not consulted a physician within five years, were material warranties contributing to the loss, and sufficient to avoid the policy.

(For other cases, see *Insurance*, Cent. Dig. § 560; Dec. Dig. § 265.)

3. INSURANCE—LIFE INSURANCE—ESTOPPEL AFFECTING RIGHT TO AVOID POLICY—KNOWLEDGE OF AGENT.

Where an applicant for a policy of life insurance told the agent that he was afflicted with some ailment, the nature of which was not disclosed, and that he had been treated by a physician, the agent remarking that deceased did not appear to have anything the matter with him, and that he would consult the medical examiner, the agent did not have knowledge from the statements of the insured which could be imputed

* Decision rendered, June 16, 1916. 158 Pac. Rep. 82.

to the company sufficient to estop it to question the validity of the policy on the ground of false representation concerning his freedom from disease.

(For other cases, see Insurance, Cent. Dig. §§ 968, 975-997; Dec. Dig. § 378[1].)

Department 2. Appeal from Superior Court, Lewis County; A. E. Rice, Judge.

Action by Elizabeth Quinn against the Mutual Life Insurance Company of New York. Judgment for plaintiff, and defendant appeals. Reversed and dismissed.

Hughes, McMicken, Dovell & Ramsey, of Seattle, for Appellant.

H. E. Donohoe, of Chehalis, and C. D. Cunningham, of Centralia, for Respondent.

FIRE, TORNADO, ETC.**SUPREME COURT OF MINNESOTA.**

KING

vs.

HARTFORD FIRE INS. CO. OF HARTFORD, CONN.

SAME

vs.

SPRINGFIELD FIRE & MARINE INS. CO. OF SPRINGFIELD, MASS.
(Nos. 19738 [133], 19739 [134].)***1. INSURANCE—FORFEITURE—GROUNDS—“ASSIGNED.”**

A policy of fire insurance provided that it should become void if the property insured was “assigned” without the permission of the insurer, and further that any change material to the risk should avoid the policy unless the company was promptly notified thereof. The insured gave a bill of sale of the insured property as security for an indebtedness, retaining possession. It is held:—

The insured property was not “assigned” in violation of the provision of the policy by giving the bill of sale, which was in legal effect a chattel mortgage.

(For other cases, see Insurance, Cent. Dig. §§ 795, 798, 813, 814, 818-822; Dec. Dig. § 328[2].)

(For other definitions, see Words and Phrases, First and Second Series, Assigned.)

2. INSURANCE—ACTIONS—QUESTIONS FOR JURY.

Whether there was a change material to the risk was a question for the jury, and its finding thereon is sustained by the evidence.

(For other cases, see Insurance, Cent. Dig. §§ 1737-1740, 1758-1760; Dec. Dig. 668[5].)

Appeal from District Court, St. Louis County; Herbert A. Dancer, Judge.

Actions by George R. King against the Hartford Fire Insurance Company of Hartford, Connecticut, and by the same plaintiff against the Springfield Fire & Marine Insurance Company of Springfield, Massachusetts. From orders denying motions for judgments notwithstanding the verdict or for a new trial, defendants appeal. Affirmed.

Spencer & Spencer, of Duluth, for Appellants.

Fryberger, Fulton & Spear, of Duluth, for Respondent.

BUNN, J.

These actions were tried together in the court below and argued as one case in this court. They were brought to recover

* Decision rendered, June 23, 1916. 158 N. W. Rep. 435. Syllabus by the Court.

on fire insurance policies issued by the respective defendants on the tug Osprey, owned by plaintiff. The trial resulted in a verdict for the amount of the policy and interest against each defendant, and each appealed to this court from an order denying its motion for judgment notwithstanding the verdict or for a new trial.

The facts are not in dispute, and are as follows: On February 5, 1915, plaintiff was the owner of the steam tug Osprey, then lying in a slip in the harbor of Duluth. He applied to Duluth insurance brokers for \$10,000 insurance on the tug. The brokers placed the order for insurance with a firm in Toronto, Can., who secured a policy for \$5,000 from each of the defendant companies. The policies were "dated at Toronto, February 5, 1915," and insured the tug against loss or damage by fire for the term of one year. Each provided that it should not be valid unless countersigned by the duly authorized agent of the insurer at Toronto, and each was so countersigned. The policies were in the Ontario standard form. Each contained the following conditions:—

"Any change material to the risk and within the control or knowledge of the assured shall avoid the policy as to the part affected thereby, unless the change is promptly notified in writing to the company or its local agent."

"If the property insured is assigned without a written permission indorsed thereon by an agent of the company duly authorized for such purpose, the policy shall thereby become void, but this condition does not apply to change of title by succession, or by operation of the law, or by reason of death."

On March 9, 1915, without the consent of or notice to the insurers, plaintiff executed and delivered to F. K. Randall a bill of sale of the tug; this bill of sale was absolute on its face, and was duly recorded in the office of the collector of customs at Duluth. The tug remained in plaintiff's possession. The insurers did not know that a bill of sale of the tug had been given until after the tug was destroyed by fire, on April 15, 1915.

The answers of defendants set up the sale of the tug without their consent or knowledge, alleging that such sale and transfer was in violation of the conditions above set out. The reply alleged that the bill of sale was given as collateral security only, and that the risk was not materially increased thereby. The only issues on the trial related to this bill of sale, as to whether it constituted an "assignment" of the insured property, and whether it constituted a "change material to the risk." The evidence, admitted over defendants' objection, showed without contradiction that the bill of sale was given only as collateral security for an indebtedness of plaintiff to the City National Bank of Duluth; Randall, who was an employee of the bank, acting as trustee. The court instructed the jury that the bill of sale was in legal effect a chattel mortgage only, and did not constitute an assign-

ment of the property in violation of the conditions of the policy. The question of increase of risk was submitted to the jury under proper instructions, and was necessarily determined by the verdicts against the defendants.

The assignments of error are directed to various rulings of the trial court, but really present but two questions, which may be thus stated: (1) Was the insured property "assigned" by the giving of the bill of sale? (2) Was there a material increase of risk, as a matter of law, and is the verdict that there was not sustained by the evidence?

[1] 1. There can be no doubt that it was permissible to prove by parol that the bill of sale was a chattel mortgage, and that the evidence conclusively so proves. The question is then: Was the tug "assigned," within the meaning of the condition of the policy, when the owner gave to a creditor a chattel mortgage thereon? Plaintiff contends that these are Ontario contracts; defendants, that the law of Minnesota governs. The policies were in the Ontario standard form, were so labeled, and were dated and countersigned at Toronto. But we need not decide what law governs, further than to remark that defendants should not complain if we follow the decisions of the Canadian courts hereinafter referred to, finding nothing conflicting with them in the decisions in this state or in this country.

Defendants rely strongly upon the definition of the words "assignment" and "assign" as given in dictionaries and in decided cases, asserting that an "assignment" of property is a transfer by one person to another of the whole of any property, "or of any estate or right therein." The argument is that a chattel mortgage, as between the parties, passes not only an estate or right in the property to the mortgagee, but the legal title, leaving only a right of redemption in the mortgagor. This is all true, but it does not determine that the parties to the contracts involved in the cases at bar intended by the language used to provide that the giving of a chattel mortgage on the insured property avoided the policies. Notwithstanding the chattel mortgage, plaintiff still had possession of the insured property and an interest therein to protect by insurance; he still had an insurable interest. The cases hold quite generally that what such a provision as the one under discussion is intended to provide against is a transfer or assignment of the insured's entire interest in the property, so that he does not retain an insurable interest, and that a chattel mortgage is not such a transfer or assignment. The Canadian cases interpreting the identical provision, which is a part of the form required by the Canadian law, are uniformly to the above effect. *Sands vs. Standard Fire Ins. Co.*, 26 Grant, Ch. 113, 27 Grant, Ch. 167; *McQueen vs. Phoenix Mutual Life Ins. Co.*, 4 Sup. Ct. Rep. 33; *Wade vs. Rochester German Ins. Co.*, 23 Ontario Law Reports, 636; *Pritchard vs. Merchants' Marine Ins. Co.*, 26 N. B. 232. The American cases, while not so directly

in point because not involving a construction of the precise language used in the Canadian form, are not in conflict, but, on the contrary, are in accord, generally speaking, on the proposition that giving a chattel mortgage does not divest the insured of all insurable interest in the property, and is not an "assignment" of the property within the meaning of conditions providing for forfeiture if the interest of the insured be "assigned" without the consent of the insurer. *Holbrook vs. American Ins. Co.*, 12 Fed. Cas. 319, 1 Curtis, 193; *Hitchcock vs. Insurance Co.*, 26 N. Y. 68; *Griffey vs. Insurance Co.*, 100 N. Y. 417, 3 N. E. 309, 53 Am. Rep. 202; *Bryan vs. Traders' Ins. Co.*, 145 Mass. 389, 14 N. E. 454; *Loy vs. Home Ins. Co.*, 24 Minn. 315, 31 Am. Rep. 346. Many other cases might be cited to the same purport, but it is not necessary. The authorities relied on by defendant do not hold the contrary; they are cases either where there was an absolute transfer by the insured of his entire interest, or where the policy contained an express provision against mortgaging the property.

We hold that by giving this chattel mortgage the insured property was not "assigned" within the meaning of that word as used in the policies sued upon.

[2] 2. We are unable to hold that as a matter of law the risk was materially increased by giving the bill of sale, or chattel mortgage, or that the finding of the jury on this question is not supported by the evidence. Increase of risk is always a question for the jury, unless in a particular case the evidence is so conclusive that reasonable minds cannot differ.

The question was for the jury in the case at bar, and its decision must stand.

We find no other points that require mention. The order in each case is affirmed.



**SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FIRST DEPARTMENT.**

POTOMAC INS. CO. OF DISTRICT OF COLUMBIA

vs.

KELLY.*

**1. INSURANCE—ACCOUNTING BY AGENT—FOUNDATION OF
RIGHT OF ACTION—FIDUCIARY RELATION.**

A fiduciary relation existed between a fire insurance company and the party who contracted with it to act as its general agent for the United States and Canada, to establish an agency, maintain a field and office force, give his personal attention to the management, and render the

* Decision rendered, July 10, 1916. 160 N. Y. Supp. 161.

insurance company monthly statements or accounts, and an action lay against him by the company for an accounting.

(For other cases, see *Insurance*, Cent. Dig. §§ 107, 108; Dec. Dig. § 82.)

2. INSURANCE—ACCOUNTING BY AGENT—EQUITABLE ACTION—BURDEN OF PROOF.

In an action by a fire insurance company against its general agent for an accounting, the burden was on the agent to show he had turned over to plaintiff all the moneys collected by him and to which it was entitled.

(For other cases, see *Insurance*, Cent. Dig. §§ 107, 108; Dec. Dig. § 82.)

3. INSURANCE—ACCOUNTING BY AGENT—RIGHT OF ACTION—RENDITION OF STATEMENTS.

The fact that the general agent of a fire insurance company rendered statements from time to time, which were retained without objection, did not deprive the company of its right to have a full and complete account of the agent's dealings, if it so desired.

(For other cases, see *Insurance*, Cent. Dig. §§ 107, 108; Dec. Dig. § 82.)

4. INSURANCE—ACCOUNTING BY AGENT—RIGHT OF ACTION—SHOWING OF MONEY DUE.

To have an accounting against its general agent, it was not necessary for plaintiff fire insurance company to show that anything would be found due it from the agent; it being sufficient that a fiduciary relation existed between the parties, entitling the company to a full statement of the agent's acts as such.

(For other cases, see *Insurance*, Cent. Dig. §§ 107, 108; Dec. Dig. § 82.)

Cross-Appeals from Special Term, New York County.

Action by the Potomac Insurance Company of the District of Columbia against John A. Kelly. From an interlocutory judgment (91 Misc. Rep. 335, 155 N. Y. Supp. 98), directing defendant to account, both parties appeal. Judgment modified, as indicated in the opinion, and, as modified, affirmed.

Argued before Clarke, P. J., and McLaughlin, Scott, Dowling, and Davis, JJ.

Stephen P. Anderton, of New York City, for Plaintiff.
Edgar J. Nathan, of New York City, for Defendant.

McLAUGHLIN, J.

Appeal by both parties from an interlocutory judgment directing the defendant to account. Plaintiff is a fire insurance company, with offices in Washington, D. C. Defendant is a resident of New York City. On the 12th of January, 1909, he was appointed by the plaintiff its agent for the United States and Canada, excepting the District of Columbia and its immediate vicinity, for a term of five years, under a written contract which fixed his compensation at 37½ per cent of the net premiums received on policies written through his office. Defendant agreed, for the compensation stated, to establish an agency, to maintain an efficient and capable field and office force, to give his personal attention to the management, and to render to the plaintiff

monthly statements or accounts. Immediately following the execution of the contract the plaintiff entered upon the discharge of his duties, and continued to act as plaintiff's agent until February 17, 1913. He issued and canceled policies on behalf of the plaintiff, collected premiums, adjusted and paid losses, and from time to time rendered statements to the plaintiff of the policies written and the amount of moneys collected and disbursed.

[1, 4] The evidence clearly established that, acting under this contract, his relation to the plaintiff was a fiduciary one, and the action lies for an accounting. The burden is upon him to show that he has turned over to the plaintiff all of the moneys collected by him and to which it is entitled. *Marvin vs. Brooks*, 94 N. Y. 71. The fact that he rendered statements from time to time, which were retained without objection, does not deprive the plaintiff of its right to have a full and complete account of defendant's dealings, if it so desires. *Jordan vs. Underhill*, 91 App. Div. 124, 86 N. Y. Supp. 620; *Frethey vs. Durant*, 24 App. Div. 58, 48 N. Y. Supp. 839. To obtain an accounting, it is not necessary for the plaintiff to show that anything will be found due. It is sufficient that the relation exists between the parties, and this entitles the plaintiff to a full and complete statement of his acts as agent. But, from the theory upon which the case was tried and decided, as well as the manner in which it was presented by the plaintiff on appeal, it would seem that the plaintiff does not want an accounting under the contract referred to, but does desire one from May 1, 1911, when it is claimed another contract was entered into. The interlocutory judgment does not direct the defendant to account from January 12, 1909, but only from May 1, 1911, when the alleged second contract was made.

[5] About the time the contract was made, January 12, 1909, the defendant purchased a majority of plaintiff's capital stock. Some time in 1909 he became acquainted with one Norie-Miller, the general manager of the Central Accident, Fire & Life Assurance Company of Perth, Scotland, whom he finally interested in the plaintiff's company. Defendant went to Perth in April, 1911, and saw Norie-Miller, with whom he arranged for the sale of his stock in plaintiff to the General Accident Company. The sale of the stock also contemplated that the Accident Company should acquire the balance of the stock in plaintiff, either through the defendant or others. On May 1, 1911, Norie-Miller wrote a letter to the defendant, referring to the purchase of his stock, and saying:—

"We are agreeable to appoint you as our manager for that business in the United States on the terms arranged, namely, you to be paid a straight commission of 35 per cent on the net premiums received, this to cover every commission and expense, including taxes and any other special charge, and you to receive also a contingent commission of 10 per cent on the net ascertained profits, such profits to be arrived at after deduction of

necessary reserves. * * * Formal agreement to this effect will be submitted by us to you with the usual clauses and conditions, * * * and shall send you draft of the necessary agreement in the course of a day or two."

Upon receipt of this letter the defendant indorsed upon it:—
“Perth, 1st May, 1911.
“The foregoing is accepted this day. Jno. A. Kelly.”

No formal contract was ever presented, but the court, on the theory that the letter itself constituted a contract, has directed an accounting from its date. It did not constitute a contract. It was, at most, the statement of what the contract, when presented, would contain. It was not executed by the plaintiff, and there is nothing to indicate that it was intended to be a binding contract between the parties. The defendant continued as agent until May 23, 1913, and transacted business for the plaintiff in substantially the same way that he had prior to the time the letter was written. The contract of January 12, 1909, had not been terminated, and therefore, if the plaintiff is entitled to an accounting at all, it is under that contract, and not under the letter referred to.

It follows that upon the defendant's appeal the judgment should be modified, so as to direct an accounting, if the plaintiff so desires, of the defendant's acts as agent under the contract of January 12, 1909.

The plaintiff's appeal is from so much of the judgment as holds that the defendant was entitled to a contingent commission of 10 per cent on the net ascertained profits of the plaintiff's business. In the letter to which reference has been made there is a statement to that effect, but, as has already been indicated, this letter never ripened into a contract, and for that reason the interlocutory judgment is erroneous, in that it directs such an accounting. Defendant is not entitled to a contingent commission of 10 per cent on the net ascertained profits. The contract under which the services were rendered contains no such provision, and the interlocutory judgment should also be modified in this respect.

The judgment appealed from is modified, as indicated in this opinion, and, as thus modified, affirmed, without costs to either party. The order to be entered herein, which will be settled on notice, should contain the necessary modification of the findings. All concur.

SUPREME COURT OF NEW YORK.
APPELLATE TERM, FIRST DEPARTMENT.

GREENBERG

vs.

FIREMEN'S INS. CO.*

I. INSURANCE—FIRE INSURANCE—VALUE OF STOCK—SUFFICIENCY OF EVIDENCE.

In an action for a loss by a candy dealer, evidence held insufficient to support finding that plaintiff's stock of goods before the fire was worth only \$300.

(For other cases, see Insurance, Cent. Dig. § 1722; Dec. Dig. § 665[4].)

2. INSURANCE — FIRE INSURANCE — FRAUD — BURDEN OF PROOF.

In an action for a fire loss, the burden of proving fraud is upon the insurer.

(For other cases, see Insurance, Cent. Dig. §§ 1650-1652, 1654-1656; Dec. Dig. 646[2].)

Appeal from Municipal Court, Borough of Manhattan, First District. Action by Abraham Greenberg against the Firemen's Insurance Company. From a judgment dismissing plaintiff's complaint on the merits, plaintiff appeals. Judgment reversed, and new trial granted.

Argued June Term, 1916, before Guy, Bijur, and Philbin, JJ.

Kaufman & Gisnet, of New York City (Michael Kaufman, of New York City, of counsel), for Appellant.

S. J. Rosenblum, of New York City (Wm. A. Walling, of New York City, of counsel), for Respondent.

BIJUR, J.

Plaintiff sues for a fire loss under defendant's policy of insurance for \$500. Plaintiff, a candy dealer, testified that by a fire in his premises he sustained a total loss of his entire stock (less about \$20 worth), valued by him at \$1,800. He held two policies of insurance, of \$500 each, and claimed from each company the full amount of the policy. Plaintiff's adjuster, called as a witness by him (solely on the point that the proof of loss had been prepared and filed, and as to conversations about a possible adjustment of the claim), testified on cross-examination as follows:

"Q. Did you see this debris or trash in the premises? A. I did. Q. And from your knowledge as an adjuster of fire losses of twenty years' standing, what would you say was the value of the merchandise out of sight and in this paper, in this debris—what it amounted to? A. To the best of my knowledge, it would not amount to \$1,800. Q. How much would it amount to, to the

* Decision rendered, June 26, 1916. 159 N. Y. Supp. 837.

best of your knowledge? A. I seen there some of the ceiling was down—There was a fire in the place— Q. No; how much, to the best of your knowledge, would that debris amount to? A. Probably \$300 or \$400. The court: Three or four hundred dollars, he says. Q. Is that the utmost? A. To the best of my knowledge."

When questioned about the proof of loss, he said:—

"I told the assured to make up his own schedules of total loss and missing, because he said he had that there. I did not see his place before the fire. * * * Mr. Fryer [defendant's adjuster] asked me who made that schedule, and I told him that that is the assured's own schedule of the total loss and missing. Q. Did you tell him that you would not assume responsibility, nor would you certify to the correctness of the amount? A. I did tell that to Mr. Fryer at the meeting."

Fryer, the defendant's adjuster, testified:—

"Q. What, in your opinion, was the value of the property which went to make up this debris and which is described as out of sight? A. Possibly \$300."

On cross-examination he said:—

"Q. When you say this debris of the loss was \$300, that is a rough guess, isn't it? A. Not so very rough. * * * Q. You know, as a matter of fact, that candies—they are made out of sugar and chocolate? A. Yes, sir. Q. And they melt? A. Yes, Sir. Q. And do you mean to say that you could tell, after a complete loss, how much the value of the stock was prior to the fire. A. *I said approximately.*"

There was some evidence to the effect that the witness was the only adjuster for both companies, and that the other company had paid \$450. He was asked on cross-examination:—

"Q. You never instructed the Ben Franklin Company to pay \$450, did you? A. I do not know whether I did or not. Q. Will you swear that you did not? A. No."

The witness later explained that:—

"We often overpay losses very much against our will. Q. Is it possible you overpaid here? A. I know it. * * * We buy our peace."

It is not clear what the basis of the learned court's judgment dismissing plaintiff's complaint on the merits may have been, because defendant did not move, either at the close of plaintiff's case or of the whole case, for an affirmative judgment on the ground of fraud, but only to dismiss the complaint on the ground that plaintiff had failed to prove facts sufficient to constitute a cause of action.

There was some dispute as to whether plaintiff had filed a proof of loss within the time required by the policy or at all. Whether that item entered into defendant's counsel's consideration in moving to dismiss cannot be determined from this record.

[1, 2] Laying aside, however, any technical question involved in the ground of the motion for a dismissal, I do not think that the record presents sufficient proof to support a finding of fact that plaintiff's stock of goods before the fire was worth only \$300, and there is no evidence, other than the disparity between that amount and plaintiff's claim, upon which to base a finding of fraud. The stock was of a character admittedly subject to total destruction. The debris, therefore, at the best would not represent more than a part of the stock. The opinion of both adjusters is so qualified as to make it highly unsatisfactory. Since the burden of proving fraud was on the defendant, the absence of testimony based on plaintiffs' inventory and proof of loss in detail, all of which was manifestly available is, to say the least, highly significant.

Plaintiff should not be subjected to forfeiture of all claim for loss upon testimony so vague, but both sides should have an opportunity to litigate upon adequate and appropriate proofs an issue of this importance.

Judgment reversed, and new trial granted, with \$30 costs to appellant to abide the event. All concur.

SUPREME COURT OF NEW YORK.
APPELLATE TERM, FIRST DEPARTMENT.

WEIMAN ET. AL.

vs.

NATIONAL BEN FRANKLIN FIRE INS. CO. OF PITTSBURGH, PA.*

INSURANCE—FIRE INSURANCE—PROOF OF LOSS—INVENTORY—NECESSITY.

A fire insurance clause requiring the insured to include in his proof of loss a complete inventory of quantity, cost, cash value, and amount claimed on each article is inapplicable to damage to a building, and errors and omissions in attempting such statement constitute no bar to recovery.

(For other cases, see Insurance, Cent. Dig. § 1341; Dec. Dig. § 542[2].)

Appeal from City Court of New York, Trial Term.

Action by Andrew Weiman and another against the National Ben Franklin Fire Insurance Company of Pittsburgh, Pa. Judgment for defendant, and plaintiffs appeal. Reversed and remanded.

Argued June term, 1916, before Guy, Bijur, and Philbin. JJ.

* Decision rendered, June 21, 1916. 159 N. Y. Supp. 698.

Henry L. Slobodin, of New York City, for Appellants.
S. J. Rosenblum, of New York City (Arthur C. Mandel, of New York City, of counsel), for Respondent.

BIJUR, J.

This action was brought to recover damages caused by fire to plaintiffs' building. The motion to dismiss was based on the fact that the assured had not given in their proof of loss "a complete inventory, stating the quantity and cost of articles and the amount claimed thereon, the cash value of each item thereof and the loss thereon."

In the first place, it is perfectly evident from the context that this provision relates to "personal property" mentioned in the same clause of the policy immediately preceding this requirement; but, apart from that, it is quite manifest, as a matter of common sense, that it could not refer to fire damage to a building. Plaintiffs may have been overindustrious in incorporating in their proof of loss what they call "a schedule of the damage sustained by the premises," and which is manifestly the detailed estimate of some contractor for repairing the damage. All that can be said of this statement is that it was a plain indication of plaintiffs' good faith in furnishing defendant with all the information in plaintiffs' possession, and going much further than the terms of the policy required under the circumstances. Surely, however, this is no ground for the dismissal of the complaint. These considerations seem to me to be so evident that it is unnecessary to refer to the principle enunciated in cases like *McNally vs. Phoenix Ins. Co.*, 137 N. Y. 389, 33 N. E. 475, and the many cases which have followed it. See, for example, *Glazer vs. Home Ins. Co.*, 190 N. Y. 11, 82, N. E. 727.

Judgment reversed, and new trial ordered, with costs to appellants to abide the event. All concur.

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SUPREME COURT OF OHIO.

NATIONAL FIRE INS. CO.

vs.

DENNISON. (No. 14776.)*

1. INSURANCE—CONCURRENT INSURANCE—RECOVERY ON FIRE POLICY.

An insurance company issued three separate policies of insurance, one covering a frame building and two covering a stock of goods, furniture, and fixtures contained therein. At the time of the fire there was con-

* Decision rendered, Feb. 15, 1916. 113 N. E. Rep. 260. Syllabus by the Court.

current insurance by other companies on the same property in specified amounts. Each of these policies contained a stipulation that the company should not be liable under the policy for a greater proportion of any loss on the described property than the amount thereby insured should bear to the whole insurance, whether valid or not, or by solvent or insolvent insurers, covering such property. The insured suffered partial loss by fire on both the building and personality, *held*:—

In such action, on the policy issued on the building, the insured could recover for the full amount of the partial loss thereon, and was not limited by any such stipulation to a proportionate amount that such policy bore to the whole insurance.

(For other cases, see Insurance, Cent. Dig. §§ 1285-1290; Dec. Dig. § 504.)

2. INSURANCE—FIRE POLICY—STIPULATION LIMITING LIABILITY—VALIDITY.

As to the building, such stipulation limiting liability and payment for the actual partial loss, was void by reason of the valued policy law. Sections 9583 and 9584, General Code.

(For other cases, see Insurance, Cent. Dig. §§ 1270-1272; Dec. Dig. § 495[1].)

3. INSURANCE—FIRE INSURANCE—VALUED POLICY LAW—OPERATION.

These sections of the valued policy law apply to buildings and structures named therein and do not affect insurance contracts covering personal property.

(For other cases, see Insurance, Cent. Dig. §§ 1270-1272; Dec. Dig. § 495[1].)

4. INSURANCE—FIRE POLICY—STIPULATIONS LIMITING LIABILITY—PERSONAL PROPERTY—CONCURRENT INSURANCE.

As to personal property, the stipulations named in the policy are valid, and recovery based upon insurance contracts containing such stipulations is limited to the proportion of the loss that the amount thereby insured bears to the whole insurance.

(For other cases, see Insurance, Cent. Dig. §§ 1270-1272, 1285-1290; Dec. Dig. §§ 495[1], 504.)

Wanamaker, J., dissenting.

(Additional Syllabus by Editorial Staff.)

5. INSURANCE—COINSURANCE—“CONTRIBUTION.”

In insurance law, the term “contribution” has a fixed legal meaning. It is a principle sanctioned in equity, and arises between coinsurers only, permitting one who has paid the whole loss to obtain contribution from other insurers, who are also liable therefor.

(For other cases, see Insurance, Cent. Dig. §§ 1502, 1503; Dec. Dig. § 604.)

(For other definitions, see Words and Phrases, First and Second Series, Contribution.)

Error to Court of Appeals, Fairfield County.

Action by one Dennison against the National Fire Insurance Company. A judgment for plaintiff was affirmed by the Court of Appeals, after ordering a remittitur to correct a manifest mistake in the verdict, and defendant brings error. Reversed.

This was an action by the defendant in error against the National Fire Insurance Company on three separate policies. One policy was for the

sum of \$1,000 on a frame building occupied as a general store. The second policy was for the sum of \$1,000 on the stock of goods, furniture, and fixtures therein, \$20 of that amount being upon the furniture and fixtures, and the third policy was issued for the sum of \$2,000, \$40 of which was placed upon the furniture and fixtures. The petition averred, and the answer admitted, that after the fire a written agreement was entered into between the insurer and the insured by which the amount of the loss on the building was fixed and determined in the sum of \$225, and the amount of loss upon the stock of goods was likewise fixed and determined in the sum of \$2,106.43. By a similar arrangement the actual loss on the furniture and fixtures was determined to be in the sum of \$100. Each of the policies contained a clause granting permission for other concurrent insurance.

The insurance company filed an answer containing several defenses to the cause of action set forth in the petition. It alleged that each of the policies of insurance contained a stipulation providing that the company should not be liable under the policy for a greater proportion of any loss on the described property than the amount thereby insured should bear to the whole insurance, whether valid or not, or by solvent or insolvent insurers covering such property, and further alleged in its several defenses that at the time of the fire there was concurrent insurance other than said policies of insurance, severally named in the petition, that upon the frame building mentioned in the petition there was concurrent insurance to the amount of \$1,000, and that there was concurrent insurance other than the policies of insurance described in the petition upon the stock of general merchandise in the sum of \$6,860, and further concurrent insurance in the amount of \$140 on the furniture and fixtures. Each policy in suit contained the following provision:—

"This company shall not be liable under this policy for a greater proportion of any loss on the described property * * * than the amount hereby insured shall bear to the whole insurance, whether valid or not, or by solvent or insolvent insurers, covering such property."

In support of this feature of its defense the insurance company sought to show by an examination of the defendant in error that there were other policies of insurance issued and outstanding at the time of the fire upon the property covered by the policies, and that such concurrent insurance had been issued by the *Aetna Insurance Company* and was in force at that time. The court refused the admission of this testimony, whereupon counsel for the insurance company offered explicitly to show that the *Aetna Insurance Company* had issued a concurrent policy in the sum of \$1,000 on the building, and another policy for \$1,960 on the stock of goods and an additional \$40 on the furniture and fixtures.

Upon the question of recovery, the parties having admitted by the pleadings mutual determination of the amount of the loss to the building and personal property, the court charged the jury as a matter of law that the plaintiff was entitled to recover the full amount of such determined loss with interest. A verdict for the full amount was rendered by the jury, and the judgment thereon was affirmed by the court of appeals after ordering a remittitur in the sum of \$40 which manifestly was erroneously incorporated in the verdict.

J. W. Mooney and R. M. Edmonds, both of Columbus, and W. K. Martin, of Lancaster, for Plaintiff in Error.

M. A. Daugherty, J. S. Sites, and Brooks E. Shell, all of Lancaster, for Defendant in Error.

JONES, J.

The contention of the plaintiff in error is that, in view of the stipulations in its several policies limiting its liability in case of concurrent insurance, its liability is fixed thereby, and that under such

condition such liability, "where the whole loss upon an item of property is less than the total amount of insurance upon such item, is limited to such proportion of the whole loss upon that item as the amount insured by that company bears to the total insurance covering that item of property, and that under this condition of the policy the liability of each insurance company is several and not joint."

[1, 2] It has generally been held by the courts of this country that, in the absence of a statute affecting the limitation of liability upon the part of the insurer, a stipulation of the character contained in this policy may serve to fix and limit a ratable liability measured by the proportion of its insurance to the aggregate insurance. In such cases the courts have generally held that such a provision, in case of other concurrent insurance, made the liability several and not joint, and that a recovery cannot be had for more than the pro rata amount stipulated for and fixed by the parties in their insurance contract.

This principle was announced by our own court, before the passage of our valued policy law, in the case of Good vs. Buckeye Mutual Fire Ins. Co., 43 Ohio St. 394, 2 N. E. 420, where, under a similar provision, it was held that the liability of the defendant was several and not joint, and that in ascertaining the defendant's proportionate share of the entire loss reference should be had to the aggregate insurance without regard to the fact that some of the companies had settled for a less sum than they were liable for, or whether they were insolvent or otherwise. The principle so announced would still obtain if not affected by a statute controlling the stipulation contained in the policy. In so far as the parties have attempted to employ this provision in fixing the liability in case of loss to buildings and structures in this state, they are confronted by our present valued policy law, which denies them this right. What is known as the valued policy law is now contained in section 9583 and 9584, General Code. These sections provide that any one insuring any building or structure against loss or damage by fire shall cause such building or structure to be examined by his or its agent, a full description thereof be made, and its insurable value be fixed by him. In the absence of any change increasing the risk without the consent of the insurer or intentional fraud on the part of the insured, section 9583 provides:—

"In case of total loss, the whole amount mentioned in the policy or renewal upon which the insurer receives a premium, and in case of a partial loss, the full amount thereof, shall be paid."

Adhering to the rule uniformly adopted in this state that this section becomes a part of every fire insurance contract, it devalues every such contract inconsistent with its provisions. This section requires in all cases of total loss to buildings and structures that the whole amount mentioned in the policy upon

which the insurer received a premium shall be paid, and furthermore that in case of partial loss the *full amount of such partial loss shall be paid*. The seeming contention of counsel for plaintiff in error is that, in the face of this statute, only a *proportion* of the partial loss shall be paid. This contention would nullify the plain terms of the statute. It is attempted to enforce this construction by reference to section 9584, General Code, which provides:—

"When there are two or more policies upon the same property, each policy shall contribute to the payment of the whole or the partial loss in proportion to the amount of insurance mentioned in each policy."

The latter section has been construed in the case of German-American Ins. Co. vs. McBee et al., 85 Ohio St. 161, 173, 97 N. E. 378, and it is there plainly shown that the inadvertent change of the word "of" to the word "to" in the separation and codification of the act was not intended to alter its apparent meaning and purpose. The original valued policy act is found in 76 Ohio Laws, 26. The two present sections were in that act united and separated by a semicolon only, the latter portion thereof providing that in case of concurrent insurance each policy "shall contribute to the *payment of the whole of the partial loss* in proportion to the amount of insurance mentioned in each policy."

[5] In insurance law the term "contribution" has a fixed legal meaning. It is a principle sanctioned in equity, and arises between co-insurers only, permitting one who has paid the whole loss to obtain contribution from other insurers who are also liable therefor. And, as the term relates to insurance, as used in the context, that is its evident meaning. It does not mean, as otherwise claimed, that the "contribution" is made to the plaintiff by each insurer, under that act, for contribution does not equitably arise between the insurer and insured. In this view, as originally enacted, the meaning of the entire section seems to be clear; that is, in cases where buildings and structures are insured, both the total loss or the partial loss must be paid by the insurer, but in case of partial loss, where there is concurrent insurance on the same property, a contribution shall accrue to the insurer paying the whole of the partial loss, from other concurrent insurers, "in proportion to the amount of insurance mentioned in each policy."

In the case at bar the facts show that only partial losses were sustained on both real estate and personality. The first section cited above imposes liability for the payment of the full amount of the partial loss upon the insurer, and the second section gives him the right of contribution against other insurers issuing concurrent insurance. Had the court, therefore, in the instant case, before it merely a policy covering the buildings and structures within the meaning of the valued policy law, there would have been no error on its part in refusing evidence showing other con-

current insurance as a means of fixing a pro rata liability under the stipulations of the insurance contract, for the reason that in such case such a stipulation would be void. Two of the policies in question, however, covered a stock of goods and fixtures, and to these the valued policy law did not apply.

[3, 4] An examination of the sections above named will show clearly that the law applied only to policies covering *buildings or structures*. There are many and vital reasons why the valued policy law should not apply to personal property which will at once occur to any one. Many of those states which have adopted valued policy statutes similar to our own have denied the application of the statute to personal property and applied it to realty only. And in so far as the Ohio courts have passed upon the subject, this view has been sustained in the opinions in the following cases: Insurance Co. vs. Leslie, 47 Ohio St. 409, 414, 24 N. E. 1072, and Germania Fire Ins. Co. vs. Werner, 76 Ohio St. 543, 553, 81 N. E. 980, 12 L. R. A. (N. S.) 456, 118 Am. St. Rep. 891.

Inasmuch, therefore, as the valued policy act did not affect insurance contracts relating to property other than buildings and structures within the terms of that statute, it did not attempt to interfere with contractual relations of parties to insurance contracts covering the personal property described in the second and third policies of insurance in this case, and as to them the principle adhered to by the courts of this country, and as announced in the case of Good vs. Buckeye Mutual Fire Ins. Co., *supra*, obtains, which is that as to those policies the contract is for a several liability, and the parties may, as stipulated, agree upon a fixed liability for a proportionate share of the entire loss. While there has been no Ohio case presenting the question here involved the principle here announced is consistent with the court's prior adjudications upon this subject. The case of Good vs. Buckeye Mutual Fire Ins. Co., *supra*, was decided upon a policy issued ten months before the passage of the valued policy law and therefore the rule announced in that case cannot now apply to the insurance on buildings and structures within the meaning of that act. But the case sustains the view that, unaffected by the valued policy law, the policy condition would be valid and would cover both buildings and personality. On the other hand, where *personalty* was involved under a similar policy stipulation, in the case of Royal Insurance Co. vs. Ries, 80 Ohio St. 272, 88 N. E. 638, it was held that, although fixed by appraisement, the amount the plaintiff could recover was limited to a proportionate amount of the loss determined; while in the case of German-American Ins. Co. vs. McBee et al., *supra*, where the policy was issued upon *structures and buildings* within the meaning of the statute, and which also contained a stipulation of liability limitations similar to the present case, the plaintiffs recovered a judgment for the full amount of the total loss, evidently

under the provisions of the valued policy act and in the face of such limitations. Had the loss in that case been partial, and not total, in view of the provisions of that act that in case of a partial loss the full amount thereof should be paid a judgment for the full amount of the partial loss would no doubt have been sustained, leaving the equitable right of contribution under that act to be threshed out between the coinsurers of the property.

In our view of the case, therefore, under the stipulations of the two policies relating to personal property, the court should have admitted evidence showing the amount of concurrent insurance on the same property at the time of the fire, and should have charged that, as to such property, the defendant was liable only for the proportionate share of the loss, as stipulated by the contract, but as to the frame building, covered by the first policy, it was the duty of the court to charge that the defendant was liable for the full amount of the partial loss sustained.

The judgment of the lower courts, for the reasons stated, will therefore be reversed, and the cause remanded to the common pleas court for further proceedings according to law.

Judgments reversed.

Johnson, Newman, and Matthias, JJ., concur. Wanamaker, J., dissents. Nichols, C. J., not participating.



ÆTNA INS. CO. ET AL. vs. HANN ET AL. (6 Div. 334.)*

(Supreme Court of Alabama.)

8. INSURANCE—ESTOPPEL.

An insured whose property was destroyed by the alleged negligence of a third party in constructing a wall which fell upon it by recovering against such third party would diminish his loss *pro tanto*, so that his right to recover against the insurers would be limited to the remainder only of the loss covered by his policies.

(For other cases, see Insurance, Cent. Dig. §§ 1504-1508, 1511, 1515, 1516; Dec. Dig. § 606[1].)

9. INSURANCE—SUBROGATION—ACTION FOR BENEFIT OF INSURER.

In such case the insured, receiving the whole loss from the insurer, would hold his claim against such third party in trust for the insurer, and might sue therefor in his own name for its use, or the insurer might sue in his own name for its own use.

(For other cases, see Insurance, Cent. Dig. §§ 1504-1508, 1511, 1515, 1516; Dec. Dig. § 606[1].)

* Decision rendered, June 1, 1916. 72 South. Rep. 48.

10. INSURANCE—PARTIES SECONDARILY LIABLE—PAYMENT.

Before subrogation could be decreed in favor of an insurer as against one primarily liable for the loss, the insurer must have paid the insured his loss according to his policy, and so satisfy the insured's demand against the wrongdoer.

(For other cases, see Insurance, Cent. Dig. §§ 1504-1508, 1511, 1515, 1516; Dec. Dig. § 606[1].)

Appeal from Chancery Court. Jefferson County; A. H. Benners, Chancellor.

Suit by the Aetna Insurance Company and others against C. Hann and others to enjoin the prosecution of several actions at law. Decree for defendants on sustaining a demurrer to the bill, and plaintiffs appeal. Affirmed.

Coleman & Coleman, of Birmingham, for Appellants.
Percy, Benners & Burr, of Birmingham, for Appellees.



HACKETT vs. CASH. (3 Div. 219.)*

(Supreme Court of Alabama.)

6. INSURANCE — FIRE INSURANCE — PAYMENT TO MORTGAGEE.

Where a policy of fire insurance is upon the interest of the mortgagee, and does not accrue to the benefit of the mortgagor, the insurance company has the right to pay the mortgage and take an assignment, or to become subrogated to the rights of the mortgagée in case there is no assignment.

(For other cases, see Insurance, Cent. Dig. §§ 1509, 1515, 1516; Dec. Dig. § 606[2].)

7. INSURANCE — FIRE INSURANCE — PAYMENT TO MORTGAGEE—SUBROGATION.

Where a policy of fire insurance is procured by the owner for his own benefit, but payable to the mortgagee as his interest may appear, payment to the mortgagee would extinguish the mortgage indebtedness.

(For other cases, see Insurance, Cent. Dig. §§ 1509, 1515, 1516; Dec. Dig. § 606[2].)

9. INSURANCE — FIRE INSURANCE — “ADDITIONAL INSURANCE”—“OTHER INSURANCE.”

If both the mortgagor and mortgagee of real estate have separate insurance upon their respective interests, then neither policy can be said to be “additional” insurance with respect to the other policy, since the terms “additional insurance” and “other insurance.” as used in

* Decision rendered, May 11, 1916. 72 South. Rep. 52.

policies providing a forfeiture, means the same insurable interest in the property.

(For other cases, see Insurance, Cent. Dig. §§ 862, 863; Dec. Dig. § 336[3].)

(For other definitions, see Words and Phrases, First and Second Series, Additional Insurance; Other Insurance.)

10. INSURANCE — FIRE INSURANCE — “ADDITIONAL INSURANCE.”

Where policy of fire insurance permitted \$1,000 additional insurance, it did not refer to a policy to which the insured was not a party and which he knew nothing about, but meant subsequent insurance.

(For other cases, see Insurance, Cent. Dig. §§ 862, 863; Dec. Dig. § 336[3].)

Appeal from City Court of Montgomery; Gaston Gunter, Judge.

Assumpsit by Thomas L. Hackett against Will Cash. From a judgment for defendant on his plea of recoupment, plaintiff appeals. Affirmed.

Steiner, Crum & Weil, of Montgomery, for Appellant.

Weil, Stakely & Vardaman, of Montgomery, for Appellee.



FIDELITY-PHENIX FIRE INS. CO. *vs.* RAY.

(6 Div. 107.)*

(Supreme Court of Alabama.)

1. INSURANCE—FIRE INSURANCE—WAIVER OF LIMITATION.

Where the plaintiff fully advised the defendant's agent at the time of the issuance of a fire policy that there was a mortgage on the property, the property being sold under foreclosure proceedings under the mortgage before the loss, the insurance company could not refuse payment under a provision in the policy that it should be void if the interest of the insured be other than unconditional and sole ownership of the property.

(For other cases, see Insurance, Cent. Dig. §§ 968, 975-997; Dec. Dig. § 378[1].)

2. INSURANCE—FIRE INSURANCE—WAIVER OF LIMITATION.

A provision of a fire policy that it should be void if, with knowledge of insured, foreclosure proceedings be commenced or notice of foreclosure sale of the property be given, was waived, under a provision in the policy authorizing insurance company to cancel by giving five days' notice, by failing to cancel the policy knowing that the property was advertised for sale for three weeks.

(For other cases, see Insurance, Cent. Dig. §§ 1037, 1038; Dec. Dig. § 390.)

3. INSURANCE—AGENTS—AUTHORITY.

An insurance company is bound by its agent's ostensible or apparent authority, which is the test of his actual power in the absence of

* Decision rendered, May 11, 1916. 72 South. Rep. 98.

knowledge of limitations thereon on the part of persons dealing with him.

(For other cases, see Insurance, Cent. Dig. §§ 116, 121; Dec. Dig. § 87.)

4. INSURANCE — FORFEITURE — WAIVER — DENIAL OF LIABILITY.

An insurance company by denying liability on one ground of forfeiture alone waives all other grounds of forfeiture or breaches of the conditions of the policy.

(For other cases, see Insurance, Cent. Dig. § 1036; Dec. Dig. § 395.)

Appeal from Circuit Court, Walker County; J. J. Curtis, Judge.

Suit by C. G. Ray against the Fidelity-Phoenix Fire Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Charles A Calhoun, of Birmingham, for Appellant.
Finch & Pennington, of Jasper, for Appellee.

CHUNN vs. LONDON & LANCASHIRE FIRE INS. CO.

(No. 29.)*

(Supreme Court of Arkansas.)

1. INSURANCE — ACTIONS — EVIDENCE — ADMISSIBILITY—LOSS.

In an action upon fire insurance policy, defense being incendiarism, exclusion of answer to plaintiff's question to manager of electric light plant, if it was not a fact that frequently the wiring of a house ignites and burns it, was not error, where there was no showing that the wiring of the house could have caused the fire.

(For other cases, see Insurance, Cent. Dig. §§ 1689, 1690, 1694; Dec. Dig. § 658.)

5. INSURANCE—ACTIONS—INSTRUCTIONS.

In an action upon fire insurance policy, defense being incendiarism, refusal of plaintiff's instruction, that she had the right to remove goods from her house without notice to the company so long as the hazard was not increased thereby, is not error, since the jury could well regard the removal as highly important as bearing upon the origin of the fire, although it did not increase the physical hazard.

(For other cases, see Insurance, Cent. Dig. § 1778; Dec. Dig. § 669[10].)

Appeal from Circuit Court, White County; J. M. Jackson, Judge.

Action by Mrs. Annie L. Chunn against the London & Lancashire Fire Insurance Company. From a judgment for defendant, plaintiff appeals. Affirmed.

R. S. Coffman, Rachels & Yarnell, and John E. Miller, all of Searcy, for Appellant.

Brundidge & Neelly, of Searcy, for Appellee.

* Decision rendered, May 29, 1916. 187 S. W. Rep. 307.

COHEN vs. HOME INS. CO.*
(Superior Court of Delaware. New Castle.)

1. INSURANCE—CONTRACT—WHAT LAW GOVERNS.

Where a fire policy is delivered and countersigned by an agent in the state of Maryland, the Maryland law governs.

(For other cases, see Insurance, Cent. Dig. § 293; Dec. Dig. § 147[2].)

2. INSURANCE—FIRE INSURANCE—WHAT LAW GOVERNS.

In determining liability under a Maryland contract of insurance, the courts of a foreign state will, where the Maryland courts have not passed on the matter, apply the general law, though as to matters passed on Maryland decisions govern.

(For other cases, see Insurance, Cent. Dig. § 293; Dec. Dig. § 147[1].)

3. INSURANCE—FIRE INSURANCE—POWERS OF AGENT.

A countersigning agent with authority to deliver policies and collect premiums has the legal power and authority to waive by parol provisions in a fire policy with respect to conditions existing prior to or at the time the policy is delivered, which are by the terms of the policy made the subject of agreement between the agent and insured.

(For other cases, see Insurance, Cent. Dig. §§ 948-951, 963; Dec. Dig. § 375[2].)

4. INSURANCE—FIRE INSURANCE—NOTICE TO AGENT.

Notice to a countersigning agent with respect to matters subject to agreement between the agent and the insured is notice to the company.

(For other cases, see Insurance, Cent. Dig. §§ 96-113, 125; Dec. Dig. 95.)

5. INSURANCE—FIRE INSURANCE—COUNTERSIGNING AGENT.

A countersigning agent authorized to deliver policies and collect premiums cannot, after delivery, and before loss, waive by parol an iron-safe clause in the policy.

(For other cases, See Insurance, Cent. Dig. § 1018; Dec. Dig. § 383.)

6. INSURANCE—FIRE INSURANCE—PROVISIONS—ESTOPPEL.

Where, after delivery of a fire policy containing an iron-safe clause, insured asked the agent who countersigned, delivered the policy and received premiums, what was meant by the clause, stating that he had no safe, and was assured that it was intended only for dishonest persons, the company is not, a loss having occurred, estopped to set up insured's failure to comply with such clause.

(For other cases, see Insurance, Cent. Dig. §§ 1026, 1027; Dec. Dig. § 388[2].)

7. INSURANCE—FIRE INSURANCE—BREACHES.

A countersigning agent who delivers a policy cannot waive future breaches.

(For other cases, see Insurance, Cent. Dig. §§ 948, 951, 963; Dec. Dig. § 375[2].)

8. INSURANCE—FIRE INSURANCE—BREACH OF CONDITION.
The holder of a fire policy which required the taking of an inventory in thirty days if one had not been taken within twelve months past,

* Decision rendered, June 5, 1916. 97 Atl. Rep. 1014.

must, in order to recover on such policy, take an inventory within the time stipulated.

(For other cases, see Insurance, Cent. Dig. § 853; Dec. Dig. § 335[2].)

9. INSURANCE — FIRE INSURANCE — IRON-SAFE CLAUSE — COMPLIANCE WITH.

Where a fire policy on a stock of goods required insured to keep his books in an iron safe or a place of safety, it was not a substantial compliance with the policy for insured to keep an inventory in a place of safety, where the other books were incomplete consisting principally of loose sheets of paper showing cash receipts, and there were no books showing purchases of goods and sales.

(For other cases, see Insurance, Cent. Dig. § 853; Dec. Dig. § 335[1].)

Action by David Cohen against the Home Insurance Company, a corporation of the state of New York. Verdict directed for defendant.

See, also, 95 Atl. 238, 912.

Argued before Rice and Heisel, JJ.

Robert H. Richards and Aaron Finger, both of Wilmington, and T. Alan Goldsborough, of Benton, Md., pro hac vice, for Plaintiff.

Richard S. Rodney, and Saulsbury, Morris & Rodney, all of Wilmington, and W. Calvin Chesnut, of Baltimore, Md., pro hac vice, for Defendant.



VAN NEST ET AL. vs. CITIZENS' INS. CO.

(No. 19865 [222].)*

(Supreme Court of Minnesota.)

INSURANCE—INSURANCE AGAINST LOSS OF RENT—CONSTRUCTION OF POLICY.

A policy of insurance against loss of rent, due to a fire which rendered the insured property untenable, provided for payment of the actual loss sustained, "not exceeding the sum insured, nor one-twelfth of that amount for any one month." A fire occurred, rendering the company liable for the loss, and the same was amicably adjusted at an amount equal to one-half the face of the policy, which was paid. A second fire occurred some three months later, resulting in a further loss. It is held that the policy remained in force after the first loss at one-half the amount thereof, and that the monthly payments to be made in discharge of liability under the second loss are limited to one-twelfth of that amount, and not one-twelfth of the original sum insured.

(For other cases, see Insurance, Cent. Dig. § 1283; Dec. Dig. § 507.)

Appeal from Municipal Court of Minneapolis; W. W. Bardwell, Judge.

Action by John H. Van Nest and others against the Citizens' Insurance Company. From an order denying a new trial, plaintiffs appeal. Affirmed.

* Decision rendered, July 14, 1916. On petition for rehearing, July 20, 1916. 158 N. W. Rep. 725. Syllabus by the Court.

Geo. B. Leonard, of Minneapolis (M. Rose, of Minneapolis, on the brief), for Appellants.

M. H. Boutelle, of Minneapolis, for Respondent.



STRAWBRIDGE vs. STANDARD FIRE INS. CO. OF HARTFORD, CONN. (No. 12017.)*

(Kansas City Court of Appeals. Missouri.)

1. INSURANCE—FIRE INSURANCE—VALUED POLICY LAW.

The valued policy law (Rev. St. 1909, § 7030) merely fixes the value of the insured property at the time of insurance, and not its value at the time of destruction.

(For other cases, see Insurance, Cent. Dig. §§ 1275, 1276; Dec. Dig. § 500.)

2. INSURANCE—FIRE INSURANCE—BURDEN OF PROOF.

In an action on a fire policy for the destruction of an automobile, an article changing in value, plaintiff has the burden of proving its value at the time of its injury.

(For other cases, see Insurance, Cent. Dig. § 1665; Dec. Dig. § 646[8].)

3. INSURANCE—FIRE INSURANCE—VALUED POLICY LAW.

Under Rev. St. 1909, § 7030, prohibiting fire insurers to take a risk at a ratio greater than three-fourths of the value of the property insured and declaring that when taken its value shall not be questioned in any proceeding, the value of an automobile insured for \$1,500 is conclusively fixed to be \$2,000 at the time the insurance was written.

(For other cases, see Insurance, Cent. Dig. §§ 1275, 1276; Dec. Dig. § 500.)

4. INSURANCE—FIRE INSURANCE—ACTIONS—EVIDENCE.

In an action on a fire policy upon an automobile, evidence *held* to warrant finding that the automobile, at the time of its destruction, was worth the sum fixed in the policy.

(For other cases, see Insurance, Cent. Dig. § 1722; Dec. Dig. § 665[4].)

5. INSURANCE — FIRE INSURANCE — EVIDENCE — DEPRECIATION.

In an action on a fire policy, evidence of depreciation of the article insured cannot be shown by proof that because it had been used by the insured it would sell for less sum than if not secondhand.

(For other cases, see Insurance, Cent. Dig. § 1695; Dec. Dig. § 660.)

6. INSURANCE — FIRE INSURANCE — ACTION — ATTORNEY'S FEES.

Where the insured, whose motorcar had been destroyed by fire, demanded the full amount of the policy and refused to discuss depreciation, the refusal of the insurance company to pay the amount of the policy cannot be deemed vexatious within Rev. St. 1909, § 7068, providing that in such case the jury may allow a penalty and attorney's fees, this being particularly true where it did not appear that the insured

* Decision rendered, June 12, 1916. 187 S. W. Rep. 79.)

offered to credit on the policy the sum he received for the wreckage, and so an attorney's fee was improperly allowed.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

Appeal from Circuit Court, Jackson County; Frank G. Johnson, Judge.
"To be officially published."

Action by Parson W. Strawbridge against the Standard Fire Insurance Company of Hartford, Conn. From a judgment for plaintiff, defendant appeals. Affirmed, on condition that plaintiff file a remittitur; otherwise, reversed and remanded.

Fyke & Snider, of Kansas City, for Appellant.
Ed. E. Yates, of Kansas City, for Respondent.



SPENCE vs. PHOENIX ASSUR. CO., LTD., or LONDON.

(No. 9427.)*

(Supreme Court of South Carolina.)

INSURANCE—FORFEITURE—WAIVER.

Failure of insurer after a fire to return the premium, or the unearned portion thereof, in accordance with the provisions of the policy providing for return in case the policy should become void, is evidence of waiver of the forfeiture.

(For other cases, see Insurance, Cent. Dig. § 1045; Dec. Dig. § 392[11].)

Appeal from Common Pleas Circuit Court of Chester County; H. F. Rice, Judge.

Action by Willie Spence against the Phoenix Assurance Company, Limited, of London. From a judgment for defendant, plaintiff appeals. Reversed.

Marion & Marion, of Chester, for Appellant.
De Pass & De Pass, of Columbia, for Respondent.

* Decision rendered, June 28, 1916. 89 S. E. Rep. 319.



STOCKWELL vs. GERMAN MUT. INS. ASS'N OF LE MARS.

(No. 3910.)*

(Supreme Court of South Dakota.)

5. INSURANCE—WAIVER OF PROOF OF LOSS.

Denial by insurer of any liability excuses compliance by the holder of a hail insurance policy with a by-law requiring a true account of crops grown, certified to by two disinterested witnesses.

(For other cases, see Insurance, Cent. Dig. §§ 1391, 1392; Dec. Dig. § 559[1].)

* Decision rendered, June 27, 1916. 158 N. W. Rep. 450.

Appeal from Circuit Court, Minnehaha County; Joseph W. Jones, Judge.

Action by Charles A. Stockwell against the German Mutual Insurance Association of Le Mars. From a judgment for plaintiff and order denying new trial, defendant appeals. Affirmed.

Bailey & Voorhees and T. M. Bailey, all of Sioux Falls, for Appellant.
Parliman & Parliman, of Sioux Falls, for Respondent.



NEW JERSEY FIRE INS. CO. vs. BAIRD ET AL.
(No. 7550.)*

(Court of Civil Appeals of Texas. Dallas.)

2. INSURANCE—FIRE POLICIES—AUTHORITY OF AGENT.

A local agent of a fire company, authorized to solicit insurance, deliver policies, and collect premiums, may waive conditions and forfeitures in the policy regardless of the authority conferred by the insurer, unless the insured knows of such limitations on his authority.

(For other cases, see Insurance, Cent. Dig. §§ 952, 955; Dec. Dig. § 376[3].)

3. INSURANCE—FIRE INSURANCE—CONDITIONS—WAIVER.

A local insurance agent authorized to waive conditions and forfeitures contained in a fire policy may waive them by parol.

(For other cases, see Insurance, Cent. Dig. § 1018; Dec. Dig. § 383.)

Appeal from District Court, Dallas County; W. F. Whitehurst, Judge.

Action by Emma C. Baird and others against the New Jersey Fire Insurance Company, in which W. T. Henry and another were made parties. From a judgment for plaintiffs, and W. T. Henry and another, defendant appeals. Affirmed.

Senter & Synnott, of Dallas, for Appellant.

Short & Field and Leake & Henry, all of Dallas, for Appellees.

* Decision rendered, May 13, 1916. Rehearing denied, June 24, 1916.
187 S. W. Rep. 356.



HOUSEMAN vs. GLOBE & RUTGERS FIRE INS. CO.*

(Supreme Court of Appeals of West Virginia.)

4. INSURANCE—PROOFS OF LOSS—WAIVER OF OBJECTIONS.

If the insurer, after being furnished an imperfect or incomplete proof of loss, resists payment on the sole ground that the insured was not the

* Decision rendered, June 3, 1916; 89 S. E. Rep. 269. Syllabus by the Court.

owner of the property, he thereby waives further proof of loss, and is estopped to set it up as a defense, when sued on the policy, notwithstanding a nonwaiver agreement entered into to preserve the rights of the parties pending an adjustment of the loss. Such nonwaiver agreement does not preclude an estoppel on account of subsequent conduct and statements of the insurer.

(For other cases, see Insurance, Cent. Dig. § 1402; Dec. Dig. § 560[2].)

5. INSURANCE—PROOFS OF LOSS—WAIVER OF OBJECTIONS.

If the adjuster makes up a proof of loss from data furnished him by the insured, or his agent, which includes an itemized list of goods saved from the fire, with the value of each item, and makes no demand that they be appraised, he thereby waives the provision in the policy relating to their appraisal.

(For other cases, see Insurance, Cent. Dig. § 1436; Dec. Dig. § 576[1].)

6. INSURANCE—FORFEITURE—IRON SAFE CLAUSE.

The insured, a retail merchant, who endeavored to conduct a cash business, and who kept a book showing his last inventory and all purchases and cash sales made by him, and preserved it in an iron safe in the building containing the property insured, has substantially complied with the promissory warranty, commonly called the "iron-safe clause," notwithstanding he occasionally sold goods on short time credit and made memoranda thereof on slips of paper or cards, which he filed away in his desk, until payment therefor was made, when he immediately entered the amount in his cash account.

(For other cases, see Insurance, Cent. Dig. § 853; Dec. Dig. § 335[4].)

Error to Circuit Court, McDowell County.

Action by W. H. Houseman, administrator, against the Globe & Rutgers Fire Insurance Company. From a judgment for plaintiff, defendant brings error. Affirmed.

Sexton & Roberts and Sanders & Crockett, all of Bluefield, for Plaintiff in Error.

Stokes & Sale, of Welch, for Defendant in Error.

ACCIDENT AND HEALTH.**UNITED STATES CIRCUIT COURT OF APPEALS.****FOURTH CIRCUIT.****PARRISH****v.s.****ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA.
(No. 1382.)*****1. INSURANCE—ACCIDENT INSURANCE—NOTICE OF LOSS.**

Where the constitution of an order fixed its liability for bodily injury effected through accidental means which occasioned death immediately or within six months from the happening thereof, and provided that in the event of death resulting from accidental means, as therein-before provided, notice of the accident must be given, and in addition notice of the death within ten days after the death, notice was required to be given in case of death resulting immediately from the injury.

(For other cases, see Insurance, Cent. Dig. § 1322; Dec. Dig. § 535.)

2. INSURANCE—ACCIDENT INSURANCE—NOTICE OF LOSS—IMPOSSIBILITY.

The fact that it might be impossible, in some cases of immediate death from accident, to give the notice of loss required by the constitution of the order does not excuse failure to give it when it was possible.

(For other cases, see Insurance, Cent. Dig. § 1334; Dec. Dig. § 539[6].)

4. INSURANCE — ACCIDENT INSURANCE — SUFFICIENCY OF EVIDENCE—SUICIDE.

In an action on a benefit insurance certificate, excluding liability for suicide, evidence held sufficient to warrant the court in refusing to direct a verdict that the insured had not committed suicide.

(For other cases, see Insurance, Cent. Dig. § 1763; Dec. Dig. § 668[12].)

5. INSURANCE—WEIGHT OF EVIDENCE—SUICIDE.

In an action on a fraternal benefit certificate, where the evidence of suicide is circumstantial, the defendant fails, unless the circumstances exclude with reasonable certainty any hypothesis of death by accident or by the act of another.

(For other cases, see Insurance, Cent. Dig. § 1720; Dec. Dig. § 665[6].)

6. INSURANCE—QUESTION FOR JURY—SUICIDE.

In an action on a fraternal benefit certificate excluding liability for suicide, though the presumption is against suicide and the defendant must show it by clear and satisfactory evidence, where there is evidence so tending to support the defense that reasonable men might differ as

* Decision rendered, Feb. 2, 1916. 232 Fed. Rep. 425.

to whether the inference of suicide or accidental death should be drawn, that inference must be drawn by the jury and not by the court. (For other cases, see Insurance, Cent. Dig. § 1763; Dec. Dig. § 668[12].)

7. INSURANCE—BURDEN OF PROOF—SUICIDE.

In an action on a fraternal benefit certificate excluding liability for suicide, the defense of suicide should be established by clear and satisfactory proof, such as is required to establish a fraud.

(For other cases, see Insurance, Cent. Dig. § 1720; Dec. Dig. § 665[6].)

In error to the District Court of the United States for the Eastern District of Virginia, at Richmond; Edmund Waddill, Jr., Judge.

Action by Bettie S. Parrish against the Order of United Commercial Travelers of America. Judgment for defendant, and plaintiff brings error. Affirmed.

Before Pritchard, Knapp, and Woods, C. J.

R. L. Gordon, Jr., of Louisa, Va. (Gordon & Gordon, of Louisa, Va., on the brief), for Plaintiff in Error.

John A. Lamb, of Richmond, Va., and Harry L. Doud, of Columbus, Ohio (Lamb & Lamb, of Richmond, Va., on the brief), for Defendant in Error.

Woods, C. J.

Bettie S. Parrish, a resident of Fluvanna County, Va., brought this action as beneficiary of a certificate or life insurance policy issued to her son, Eugene M. Parrish, as one of its members by the Order of United Commercial Travelers of America, an Ohio corporation.

By plea in abatement the defendant made the point that since the plaintiff is a resident of the Western District of Virginia and the defendant a foreign corporation, jurisdiction of the action was in the District Court for the Western District, and not the District Court for the Eastern District. This plea to the jurisdiction was overruled on the ground that the defendant had waived it by filing a general demurrer to the declaration. The demurrer was also overruled, and the defendant then set up these special pleas:—

(1) That the plaintiff had failed to comply with the following provisions of the constitution of the order:—

"In event of any accidental injury on account of which a death claim may be filed against the order, notice of the accident (not the results) must be given in writing to the Supreme Secretary within ten days thereafter, stating the full name and address of the injured member, date and full particulars of the accident and the name and address of his medical attendant.

"In event of a death resulting from external, violent and accidental means, as hereinbefore provided, notice of the accident must be given as hereinbefore provided, and, in addition, notice of the death must be given in writing to the Supreme Secretary within ten days after the death."

(2) That Eugene M. Parrish had caused his own death by in-

tentionally shooting himself in the head with a pistol; and the constitution of the order provided that there should be no liability under the policy for death resulting from intentional self-inflicted injury.

On the trial both plaintiff and defendant asked for a directed verdict. But the District Judge submitted the issues to the jury, with the result that a verdict was found for the defendant. Since the plea in abatement does not challenge the jurisdiction of the federal court, but only raises the point that the action should have been brought in the Western instead of the Eastern District of Virginia, it may be laid aside for the moment; for the plaintiff, having brought the action in the Eastern District, cannot allege that it was not properly brought, and the point is important to the defendant only in the event that reversible error be found in the conduct of the trial on the merits.

[1] The plaintiff first contends that the notice ten days after death required by the provision of the constitution above quoted has no application to a case of instantaneous death, and that the jury should have been so charged. The liability of the order as fixed by the constitution is for—

"bodily injury effected through external, violent and accidental means which alone and independent of all other causes shall occasion death immediately or within six months from the happening thereof."

It is therefore perfectly clear that the requirement of notice "in the event of death resulting from external, violent and accidental means as hereinbefore provided" applies to a death resulting "immediately" from the injury.

[2] It is true, as said in the argument of plaintiff's counsel, that cases might arise where from lack of knowledge of the death or other causes it would be impossible for the beneficiary to give notice ten days after the death. But this is not a case of that kind. The fact that a contract may become impossible of performance from circumstances beyond the control of the party obligated does not affect its validity nor relieve from performance when possible.

[3] The instructions of the court on this point were equivalent to a direct instruction to the jury that the conditions as to notice and furnishing proof of loss had been waived by the defendant. It appears clearly from the record and from the excellent statement of the evidence in the brief of counsel for the plaintiff that the facts from which the jury were told they should infer waiver were either not disputed or established by uncontested testimony. Hence it is impossible not to infer that the jury must have found that the defendant had waived the requirements of the policy as to notice and proof of death, and there is no ground therefore for the plaintiff to complain of the failure to give a direct instruction that the defendant had waived the provision of its constitution pertaining to notice and proof of death.

The important question is whether the plaintiff was entitled to an instruction that Eugene M. Parrish had not committed suicide and that the plaintiff was therefore entitled to recover. On this subject the charge was as follows:—

"The court charges you that on the issue of suicide raised by the defendant as a ground for avoiding the payment of the policy sued on, the burden of proof is upon the defendant to establish such defense. That the presumption, notwithstanding the finding of the dead body of the insured in the position described in the testimony, with his hands on the pistol lying between his legs, and the hole in his head, is that he met his death accidentally, and that the plaintiff is entitled to recover, unless the defendant can overcome the burden thus placed upon it; that is to say, unless the testimony excludes all reasonable hypothesis that the shooting was accidental, and you are convinced that the deceased intentionally took his life by inflicting the wound in his head."

The plaintiff's position is that the District Judge should have held and charged as a matter of law that the evidence did not exclude all reasonable hypotheses that the shooting was accidental, and that the verdict should be for the plaintiff.

[4] There was little difference as to the facts; the main issue is the inference to be drawn from them. Eugene M. Parrish was a traveling salesman about twenty-five years old, in excellent health, successful in business, sunny and bright in disposition, held in high esteem, and, so far as known, free from serious anxiety or trouble. Early in the afternoon of Thursday, May 27, 1911, he arrived at the Hotel Hamilton in Bristol. At supper he directed the waiter to have his breakfast on the table at 9:30 the next morning. The next morning he was found dead in his bed from a pistol shot which entered a little above the right temple. There were powder burns around the point of entrance of the ball, and on the left forefinger and perhaps the thumb. One of the witnesses testified that the ball had entered at right angles with the head, and that in his opinion the pistol could not have been fired more than eighteen inches away from the head. Deceased was lying on his back, dressed except his coat and vest, with his body turned a little to the left side, and his feet on the floor. The right hand was resting across his body and the left hand nearly straight on the bed. The pistol was on the bed between his thighs, pointing from one to the other. One chamber had been discharged, all the others were loaded. A box containing cartridges was on the mantel. The evidence was conflicting as to whether the deceased had recently acquired the pistol or had owned it for some time. Scattered on the hearth were a quantity of papers which had been torn into small pieces. Some were found to be orders for goods or other business memoranda and some letters. Two or three letters were in a woman's or boy's handwriting. A post card was formed from some of the

pieces which had on it a picture of a man and woman walking and conversing, and this writing:—

"Have you had a walk like this lately. Had a long letter from Miss M. H. You ought to see what she said, you said about me. Will show you soon."

The two doors to the room were locked, and there was nothing to indicate the presence of any other person in the room at the time of the tragedy.

[5] Did this evidence require the District Judge to direct a verdict for the plaintiff, or to leave the issue of accidental death or suicide to the jury? In *Cosmopolitan Life Ins. Co. vs. Koegal*, 104 Va. 619, 52 S. E. 166, the Supreme Court of Appeals states the rule that:—

"Where the evidence of self-destruction is circumstantial, the defendant fails, unless the circumstances exclude with reasonable certainty any hypothesis of death by accident or by the act of another."

We cite a few of the many authorities holding this rule to be now unquestioned and restating it in different forms: *Travelers' Ins. Co. vs. McConkey*, 127 U. S. 661, 8 Sup. Ct. 1360, 32 L. Ed. 308; *Life Ins. Co. of Va. vs. Hairston*, 108 Va. 832, 62 S. E. 1057, 128 Am. St. Rep. 989; *Metropolitan Life Ins. Co. vs. De Vault*, 109 Va. 392, 63 S. E. 982, 17 Ann. Cas. 27; *Sou. Atl. Life Ins. Co. vs. Hurt*, 115 Va. 398, 79 S. E. 401; *Cochran vs. Mutual Life Ins. Co. (C. C.)* 79 Fed. 46; *Fidelity & Casualty Co. vs. Egbert*, 84 Fed. 410, 28 C. C. A. 281; *Tackman vs. Brotherhood of Am.*, 132 Iowa, 64, 106 N. W. 350, 8 L. R. A. (N. S.) 974; *Cady vs. Fidelity & Casualty Co.*, 134 Wis. 322, 113 N. W. 967, 17 L. R. A. (N. S.) 260; *Wilkinson vs. Ætna Life Ins. Co.*, 240 Ill. 205, 88 N. E. 550, 25 L. R. A. (N. S.) 1256, 130 Am. St. Rep. 269; *Krogh vs. Modern Brotherhood of Am.*, 153 Wis. 397, 141 N. W. 276, 45 L. R. A. (N. S.) 404; *Bohaker vs. Travelers' Ins. Co.*, 215 Mass. 32, 102 N. E. 342, 46 L. R. A. (N. S.) 543; *Boynton vs. Equitable Life Ins. Soc.*, 105 La. 202, 29 South. 490, 52 L. R. A. 687; *Mallory vs. Travelers' Ins. Co.*, 47 N. Y. 52, 7 Am. Rep. 410.

[6] In the Virginia cases and all others to which we have referred the question was not whether the jury should have been directed to find for the plaintiff, but whether a verdict in favor of the plaintiff should be set aside on the ground that the evidence conclusively proved suicide. In view of the frequency of suicide it cannot be doubted that some courts have gone very far in applying the rule of presumption against it; but all the authorities agree that although the presumption is against suicide, and the defendant must take the burden of showing it by clear and satisfactory evidence, and that the jury should be so instructed, yet where there is evidence so tending to support the defense of suicide that reasonable men might differ as to whether the infer-

ence of suicide or accidental death should be drawn, then the inference must be drawn by the jury and not the court.

[7] We find no clearer statement of the test required by common sense than that thus given in *Life Ins. Co. of Va. vs. Hairston, supra*, by the Supreme Court of Appeals of Virginia speaking through Judge Keith:—

"We are of opinion that the defense of suicide should be established by clear and satisfactory proof, such as is required to establish a fraud."

In *Leman vs. Manhattan Life Ins. Co.*, 46 La. Ann. 1189, 15 South. 388, 24 L. R. A. 589, 49 Am. St. Rep. 348, the verdict in favor of the defendant on the issue of suicide was set aside, the court saying:—

"In this condition of the record there is no adequate basis to refer the death to the intentional act of the deceased. If there are indications that point to suicide, there are other features not consistent with that theory."

While that case and this are similar in some of the facts, there are important differences. There, as here, there was proof of death, cheerfulness, and apparent happiness, and absence of any known reason for suicide. The circumstances of death are thus stated by the court:—

"The body, found with the wound from a gunshot, causing death; the discharged pistol, wedged, or as if it had been forced, on the thumb of the right hand; the body reclining on the sofa as of one sleeping; the left arm rested on the breast; the right leg crossed on the left; the head in the usual position of one in repose; and there being no evidence of any convulsive movement, if we correctly translate the technical word 'jactitation,' used by the physicians who testify. The pistol was 'tightly wedged' to the thumb, so as to require force to remove it. The question is whether these appearances point to suicide to the exclusion of any other cause. Why not, with equal potency, to accidental death or death by the hand of another?"

In the present case there was evidence that the deceased was somewhat depressed when he left home; that there were powder burns at the wound and also on the left forefinger, indicating discharge of the pistol very close to the temple, and the use of the right hand in firing it and of the left in holding it very close to the temple. Taken in connection with this evidence, the tearing up of a large number of letters and other papers was a circumstance of significance.

We cannot doubt that these facts might well exclude in the minds of reasonable men any other inference than that the deceased intentionally shot himself; and that the issue was properly submitted to the jury.

In view of this conclusion the question of venue is of no importance.

Affirmed.

SUPREME COURT OF MINNESOTA.

McALPINE

vs.

FIDELITY & CASUALTY COMPANY OF NEW YORK.*

[The following case is an exceedingly important one, not because of the amount (the deceased had a large amount of accident insurance), but because of the points involved. Underwriters will recall the case of Johnson vs. Fidelity & Casualty Co., 45 Ins. L. J. 758, which held the accident company to be a life company. We shortly thereafter published a note to the Johnson Case (47 Ins. L. J. 744) covering the various points raised.

In the case below, plaintiffs had reliance upon the Johnson Case, *supra*, and upon Logan vs. Fidelity & Casualty Co., 146 Mo. 115, and while the court does not mention these two cases, it does nevertheless hold the defendant does not come within the life insurance provision of the Minnesota law.

The facts, all of which do not appear in the opinion, may be briefly stated as follows:—

John McAlpine carried a policy of accident insurance with the defendant. On August 15, 1913, John McAlpine's body was found in the basement of his home at Duluth with a bullet hole through his head. The bullet entered at the right temple above the ear, passed through the head to the scalp on the opposite or left side of the head, a little higher and a little farther back than it entered. The scalp where the bullet entered was powder stained. At his feet lay his own revolver with one shell in one chamber discharged; four of the other chambers were loaded, one chamber was emptied. None of the other shells were discharged. No evidence of any other shot having been fired could be found.

The immediate family consisted of his wife, the beneficiary, his son and his son's wife, with servants.

The defendant claimed that no one other than deceased, or the beneficiary, was in a position to fire the shot that killed McAlpine. The policy provided that there should be no recovery in case of suicide, sane or insane. If the beneficiary had taken her husband's life she could not profit by her own wrongful act, and could not recover under the policy. The defendant alleged three defenses: One, suicide; two, murder by the beneficiary; and three, misrepresentation and breach of warranty. After a trial lasting three weeks, in the Circuit Court of St. Louis County, the jury brought in a verdict for the defendant.]—Ed.

1. Upon the appeal of the defendant from an order granting the plaintiff's motion for a new trial, after verdict for the defendant, where the motion was granted because of errors of law occurring at the trial, and the order so stated, the plaintiff may support the order by showing other errors, if properly raised, than the specific one because of which the new trial was granted; but upon such appeal the plaintiff cannot question the sufficiency of the evidence to sustain the verdict.
2. In an action on an accident policy the provisions of R. L. 1905, Section 1623, G. S. 1913, Section 3300, relative to misrepresentation by the insured, control and not the provisions of R. L. 1905, Section 1693,

* Decision rendered, July 29, 1916. From a transcript. Syllabus by the Court.

- G. S. 1913, Section 3467, relative to misstatements as to age, physical condition and family history in an application where the policy is issued without previous medical examination or without the knowledge or consent of the insured, the policy having been written and the death claimed to be accidental, having occurred prior to the going into effect of Laws 1913, c. 156, Section 6 of which provides what shall be the effect of a false statement in an application for an accident policy.
3. In an action on an accident policy for death resulting through accidental means the defendant alleged that the death was caused by suicide, and, further, that it was caused by the beneficiary. The court denied the plaintiff's motion that the defendant be required to elect upon which claim it would rely upon the ground that the two were inconsistent. The ruling was correct. The general rule relative to inconsistent defenses will not be applied in a case like this, so as to prevent a meritorious defense or work manifest injustice. In an action on an accident policy the issue is upon the question of accident and the affirmative is upon the plaintiff. Such claims as those named may be shown under a general denial in disproof of accident. They are not affirmative defenses like misrepresentation or breach of warranty, nor are they affirmative defenses based upon an exception, as, for instance, suicide in a straight life policy. The affirmative issue, upon which the right of recovery rests, is upon the fact of accident.
 4. In such action the burden of proving that the death of the insured was caused by a third person, not the beneficiary, this constituting an accident within the meaning of the policy, is upon the plaintiff.
 5. There were no errors at the trial and a new trial should not have been granted.

Action by Sarah McAlpine against the Fidelity & Casualty Co. From an order granting plaintiff new trial. Reversed.

A. E. McManus, of Duluth (W. M. Steele, of Duluth, on the brief), for Appellant.

Briggs, Thygeson & Everall, of St. Paul (Theodore Hollister, Abbott, McPherran, Lewis & Gilbert, of Duluth, Monte Appel, of St. Paul, of counsel), for Respondent.

Opinion.

Action on a policy of accident insurance on the life of John McAlpine in which his wife, the plaintiff, was the beneficiary. There was a verdict for the defendant. The court granted the plaintiff's motion for a new trial. The defendant appeals from the order granting it.

The motion for a new trial was based upon several grounds, including that of the insufficiency of the evidence to sustain the verdict. The court granted the motion upon the ground that it erred in charging the jury relative to the effect upon the policy of a misrepresentation or misstatement by the insured of his physical condition. In its order it stated that it was granted exclusively upon the ground of errors occurring at the trial. The following questions are presented:—

(1) Whether on this appeal the plaintiff may support the order by showing errors, properly raised, other than the one for which a new trial was granted.

(2) Whether the court erred in instructing the jury relative to the effect of a misrepresentation or misstatement by the insured of his physical condition.

(3) Whether the court erred in refusing to require the defendant to elect whether it would rely upon its claim of suicide or upon its claim that the beneficiary was responsible for the death of the insured.

(4) Whether the court erred in charging the jury that the burden of proving that the insured was killed by some third person other than the beneficiary was upon the plaintiff.

(5) Whether there were other errors justifying the granting of a new trial.

If the first receives a negative answer those other than the second do not require consideration. If it is answered in the affirmative all are for consideration.

1. The plaintiff claims that there were other errors than the one made the basis of the court's order granting the new trial. The plaintiff may support the order upon any error of law properly raised justifying the granting of the motion. *Morrow vs. St. Paul, &c. Ry. Co.*, 65 Minn. 382; *Langan vs. Iverson*, 78 Minn. 299; *Poirier Mfg. Co. vs. Griffin*, 104 Minn. 239. Under Laws 1913, c. 474, section 1, subd. 4, G. S. 1913, section 8001, subd. 4, the sufficiency of the evidence to sustain the verdict is not reviewable on the plaintiff's appeal. See *Montee vs. Great N. Ry. Co.*, 129 Minn. 526; *Heide vs. Lyons*, 128 Minn. 488.

2. The defendant claimed that in his application Mr. McAlpine misrepresented or misstated his physical condition. The court at the request of the plaintiff instructed the jury as follows:—

"Any misrepresentation made by John McAlpine in the negotiation of the policy sued upon shall not be deemed to be material nor shall the same defeat recovery on the policy or prevent its attaching unless you find that he, John McAlpine, made the same with intent to deceive and defraud the defendant, or unless the matter misrepresented increased the risk of loss."

This is the substance of R. L. 1905, section 1623, G. S. 1913, section 3300, which is as follows:—

"No oral or written misrepresentation made by the assured, or in his behalf, in the negotiation of insurance, shall be deemed material, or defeat or avoid the policy, or prevent its attaching, unless made with intent to deceive and defraud, or unless the matter misrepresented increase the risk of loss."

It is claimed by the plaintiff that this section does not apply to an accident policy, but that section 1693, which reads as follows, is applicable:—

"In any claim upon a policy issued in this state without previous medical examination, or without the knowledge or consent of the insured, or, in case of a minor without the consent of his parent, guardian, or other person having his legal custody, the statements made in the application as to the age, physical condi-

tion, and family history of the insured shall be valid and binding upon the company, unless wilfully false or intentionally misleading." R. L. 1905, section 1693, G. S. 1913, section 3467.

Upon the motion for a new trial the court was of the opinion that section 1693 applied and that it was in error in charging section 1623. For this reason it granted a new trial. Both of these sections appear in the insurance code of 1895. Laws 1895, c. 175, sections 20, 71. The Massachusetts statute has provisions of the same effect. R. L. c. 118, sections 21, 73. We have not found in Massachusetts or elsewhere a construction of them.

There is a kind of life insurance where no medical examination, such as is usual with life companies, is required, and which is sometimes taken without the knowledge of the insured. It goes under the general designation of industrial life insurance. It is not accident insurance, nor casualty insurance, nor workmen's compensation. The premiums are small, often five cents a week or some multiple thereof, or other small amount paid monthly. The average amount of the insurance is small—hardly more than sufficient to pay burial expenses and give slight temporary relief. The agents of the insurance company solicit the insurance and call weekly or monthly and make collections. Sometimes insurance is taken, or in the past it has been taken, without the knowledge of the insured. The companies engaging in it write child insurance. In a way the insurance is a sort of family insurance intended as a protection against family misfortune or as an inducement to thrift and saving, and often all members of the family are insured. While the periodical premiums are small the insurance is not cheap. On the contrary, owing partly to the character of the risks and lack of discrimination in taking them and partly to the cost of administration, it is expensive. With the particular characteristics of it we are not now concerned. It is enough to know that it is a kind of insurance in common use and familiar to legislative bodies and of the general character stated. There are millions of this insurance in Minnesota. Detailed information relative to it may be obtained from the following sources: Insurance (Ind.) 11 Americana; 14 Britannica, 671; Henderson Industrial Insurance, 149; Willoughby Workmen's Ins., 212; Improvements in Industrial Life Insurance, 15 Am. Jour. Soc. 478-501; Dryden Life Insurance, 19-117; Yale Readings in Insurance, 384-399; Hoffman History of Prudential Insurance Co.; Industrial Insurance, 26 Ann. Am. Acad. Pol. & Soc. Sci. 103; Bunyon Life Ins., 308, 323; Macgillivray Ins. Law, 22; Testimony New York Legislative Insurance Investigating Committee, 1905; vol. 6, pp. 4874-4974, 5023-5075. Many reported cases illustrate industrial insurance: Thomas vs. Prudential Ins. Co., 158 Ind. 461; Floyd vs. Prudential Ins. Co., 72 Mo. App. 455; Jenkins vs. Sun Life Ins. Co., 120 Ky. 790; Ferretti vs. Prudential Ins. Co., 97 N. Y. S. 1007; Shea vs. U. S. Industrial Ins. Co., 48 N. Y. S. 548; Home Friendly Society vs.

Robertson, 100 Md. 85; Metropolitan Life Ins. Co. vs. Schaffer, 50 N. J. L. 72; Jones vs. Prudential Ins. Co., 173 Mo. App. 1; Burke vs. Prudential Ins. Co., 221 Mass. 253. In Murphy vs. Metropolitan Life Ins. Co., 106 Minn. 112, there was involved an industrial life policy, carrying a premium of five cents per week, having the usual characteristics except that there was some sort of an examination which was construed to be a medical examination within section 1693. Sometimes a medical examination is had, but usually there is only an "inspection," which is a general observation of appearance and conditions. See testimony Leg. Ins. Inv. Com. N. Y. 1905, vol. 6, pp. 4876-4881. Some states now require regular medical examinations. Industrial insurance is taken usually by wage earners who have a more or less steady but small income. The character of the people taking it and their need of protection are sometimes mentioned in the cases. Floyd vs. Prudential Ins. Co., 72 Mo. App. 455; Foryciarz vs. Prudential Ins. Co., 158 N. Y. S. 834; Public Sav. Ins. Co. vs. Manning, — Ind. App. —, 111 N. E. 945. In Baltimore, &c., vs. Howard, 95 Md. 244, the court said of industrial insurance: "The policyholders of this kind of an insurance company are generally poor and illiterate people who most need protection against harsh, technical forfeitures, because least able to appreciate their significance and because easily induced by the conduct of the company to act upon the belief that their policies are in force." The possibility of abuses is recognized. It has been held that policies taken without the consent of the insured are void. Vance on Insurance, 145; Note 53 L. R. A. 817; Note 54 L. R. A. 225; 11 Dec. Dig. Ins., section 198 (3). Some statutes require the assent of the insured. See Richards Insurance (3d ed.), 702. There has been some actual and more threatened hostile legislation and some regulative legislation. At the best it is expensive insurance giving needed help in time of distress. Those taking it are often unlettered, usually have no knowledge of the nature of an insurance contract or the effect of a misstatement, and however honest their purpose, they may express themselves inaccurately, or may speak English indifferently, and may be misunderstood, or the soliciting agents, who get their compensation from collections and gain through an increase of policies, may not be cautious or conscientious. It was the purpose of the Legislature to prevent misstatements as to age, physical condition and family history avoiding policies of this kind except when "wilfully false or intentionally misleading." It was not its purpose to favor ordinary accident policies or to put them upon a more advantageous basis than ordinary life policies. It may be noted that in Price vs. Standard Accident, &c., 90 Minn. 264, section 1623 was applied to an accident policy. Section 1693 was not mentioned. It is not questioned but that section 1623 applies if section 1693 does not. Section 1623 furnishes a rule more favorable to the policyholder than without a statute the rule

would be. It should be noted that the policy in suit was written and that death occurred prior to the going into effect of Laws 1913, c. 156. Section 6 of this act specifically provides what shall be the effect of a false statement in an application for a health or accident policy. We are not now concerned with its construction. The existence of industrial life insurance of the general characteristics noted furnishes an adequate explanation of the legislation embodied in section 1693 and determines its proper application. Their connection is not fanciful. The conclusion is not to be resisted that the statute was enacted in view of industrial insurance. There may be other kinds of life insurance, such as group insurance, to which the statute applies, but we are not now concerned with it. Nor is it necessary to determine whether, looking at the statute alone with no aid from the history of insurance in ascertaining its application, section 1693 should be held to apply only to life policies or life companies as distinguished from accident companies or accident policies. We hold that section 1623 applies to the policy in suit, that the court correctly gave it in its charge, and that a new trial should not have been granted because it was given.

We take it from the record that counsel for the defendant did not bring to the attention of the trial court the existence of industrial life insurance and the bearing of such insurance upon the constructions of section 1693.

In view of the construction adopted we find it unnecessary to discuss the question whether the plaintiff having invited the instruction given can complain of error in giving it. The settled general rule is that a party can not avail himself of invited error. See 3 Cent. Dig. App. & Err., sections 3602-3604; 2 Dec. Dig. App. & Err., section 882 (1), section 882 (12); 2 R. C. L. 238; 2 Enc. Pl. & Pr. 523. We only remark that conceding the right of the court to review in a special case the correctness of an instruction at the instance of a party who has procured it to be given a new trial should not be granted unless the charge was substantially wrong and apparently prejudicial in result. It is probable that the claimed misstatement or misrepresentation was not the important question in the case from the viewpoint of the jury.

3. The policy in suit insured Mr. McAlpine against: "Bodily injury sustained during the term of one year from noon, standard time, of the day that this policy is dated, through accidental means (excluding suicide, sane or insane, or any attempt thereat, sane or insane), and resulting directly, independently and exclusively of all other causes, in * * * (c) death."

The plaintiff claimed in her complaint that the death of McAlpine resulted from accidental means. To recover it was necessary to prove it. McAlpine was found dead in the basement of his home between 3 and 4 o'clock in the morning of August 15, 1913, with a fatal bullet wound in his head. His revolver was close by with one chamber empty. The circumstances were not

conclusive. As between accident and suicide the presumption favored accident. The defendant alleged suicide and alleged further that the death of the insured was caused by the beneficiary. In either event the plaintiff could not recover. At the opening of the case the plaintiff moved that the defendant be required to elect on which it would rely upon the ground that the two were inconsistent. This motion was denied and the plaintiff claims that it was error justifying the order granting the new trial. Our statute is as follows:—

"The defendant may set forth by answer as many defenses and counterclaims as he has. They shall be separately stated, and so framed as to show the cause of action to which each is intended to be opposed." R. L. 1905, section 4132, G. S. 1913, section 7758.

Under our decisions separate defenses must be consistent. This is not an express requirement of the statute. It has come about by construction. It is not a universal holding, nor where held, is the principle uniformly applied. See Abbott's Civ. Jur. Tr. (3d ed.), 119; Pomeroy Code Remedies (4th ed.), section 598; Bliss Code Pl., sections 342-344; Phillips Code Pl., sections 261-266; 2 Estee Pl., section 3381; 1 Enc. Pl. & Pr., 852-860; Note 48 L. R. A. 177; 16 Dec. Dig. Pl., section 93; 39 Cent. Dig. Pl., section 189. The objection upon the ground of inconsistency is not favored. *Rees vs. Storms*, 101 Minn. 381. The purpose of the code system of pleading is to get the parties to a speedy trial upon the merits. It is not to prevent the hearing of a cause of action or the interposition of a defense. We are not so much concerned with the development of an artistic and symmetrical system of pleading as we are with having a practical procedure which will result in a speedy determination of disputes upon the facts. It is sometimes said that whether both defenses can be true is the test of their consistency. An examination of the cases shows that whatever the test, defenses are not often held inconsistent. Thus it is held not inconsistent to deny a slander and allege matter in mitigation. *Warner vs. Lockerby*, 31 Minn. 421. Or to deny the rendition of services by the plaintiff and allege payment. *Steenerson vs. Waterbury*, 52 Minn. 211. Or to deny the execution of a note and allege that it was procured by fraud. *Bank of Glencoe vs. Cain*, 89 Minn. 473. Such defenses in general amount to a general denial coupled with a plea in confession and avoidance. There is an inconsistency in fact between a general denial and a plea in confession and avoidance; but the inconsistency does not prevent the interposition of both. When the rule of consistency, technically applied, prevents the interposition of a fair defense, it must yield to the insistent demand of the law that a party be given a hearing on all his causes of action and all his defenses. This is the paramount consideration. Substantive rights must not be sacrificed to preserve a rule no more important and no better accredited than the consistency rule. Naturally enough the legal mind revolts at a rule of pleading which requires

a defendant to choose which of two honest defenses he will interpose, though both cannot be true, and neither is within his knowledge, at the peril of losing all if he mistakes, for when called upon to elect he is having his final day in court. We share the view of the trial court that the situation was not one requiring an election which it expressed as follows: "It is true that the two defenses cannot both be true or correct; but it is also true that the defendants do not very well know which one may be correct; and either would be a good defense if true. * * * It would be an injustice to limit them to one when they cannot know which one, if either, is true. They should have an opportunity some time to rely upon the other, and we cannot have two trials of the same matter. Therefore the motion to elect should be denied."

Again, the affirmative of the issue tendered, that is, death by accident, was upon the plaintiff. In *Huestis vs. Aetna Life Ins. Co.*, 131 Minn. 461, where a similar accident policy was involved, and where the pleadings were similar, it was said that the plaintiff must prove the accident and that it was not incumbent upon the defendant to prove suicide. This is the result of the following authorities, some of which the court cited. *Carnes vs. Iowa State Traveling Men's Ass'n*, 106 Iowa 281; *Whitlatch vs. Fidelity & Casualty Co.*, 149 N. Y. 45; *Fidelity & Casualty Co. vs. Weise*, 182 Ill. 496; *Laessig vs. Travelers' Prot. Ass'n*, 169 Mo. 272; *Merrett vs. Preferred Masonic, &c., Ass'n*, 98 Mich. 338. "To entitle the plaintiff to recover at all, he must prove by a preponderance of the evidence that his was an accidental injury, because the policy only insured him against such injuries. It is true that when an injury is shown the presumption arises that it was not self-inflicted, and to defeat a recovery the defendant must negative this presumption; but, in cases where the only foundation of the action is accidental injury, the presumption which the law raises is only an aid to the other evidence on the subject, and does not operate to shift the burden of proof on the entire issue to the defendant. Much of the seeming conflict in the adjudicated cases on the question of the burden of proof, where a presumption arises in favor of either party, has grown out of the failure to clearly define the weight to be given to the presumption. It is quite commonly said that the burden is upon the defendant to overcome that presumption, but it is still true that after all the evidence is before the jury the burden rests where it did in the beginning. * * * If the defense were based upon the breach of some particular condition of the policy, or upon some exception therein, it would fall within the rule announced in another line of cases." *Taylor vs. Pacific, &c., Co.*, 110 Iowa, 621. The circumstances surrounding the death of the insured being shown a presumption may arise that it was accidental rather than suicidal, and as between accident and suicide the law for logical and sensible reasons supposes accident. The presumption may obviate the necessity of further proof, or its force may be such that

in a particular case a verdict may be directed for the plaintiff, but it does not change the burden in the first instance. This policy is an accident policy. To justify a recovery it must be shown that death was caused by accidental means. It is not an ordinary life policy, where liability arises from death except in certain cases, as suicide for instance, where, death being shown, liability follows unless there is an affirmative showing that the death is within an exception of the policy. In such cases proof of death is proof of a cause of action. We have not overlooked *Starr vs. Aetna Life Ins. Co.*, 41 Wash., 199, cited by plaintiff, nor the authorities collected in a note thereto in 4 L. R. A. (N. S.) 636. We have stated the doctrine approved in *Huestis vs. Aetna Life Ins. Co.*, *supra*.

It was not necessary for the defendant to allege suicide or that the death of the insured was caused by the beneficiary. Either could be proved under a general denial. Neither was an affirmative defense such as is a claim of misrepresentation or breach of warranty or suicide under a policy excepting it from the risk. The issue was upon the question whether Mr. McAlpine's death was caused by accidental means. The affirmative of this issue was upon the plaintiff. Any evidence negativing accidental means as the cause was admissible. It was not necessary, to defeat recovery, that the jurors unite in a belief of suicide, or of death caused by the beneficiary. To justify a recovery it was necessary that the jurors unite in a belief that accidental means caused the death. There was the issue.

The court correctly ruled in denying the plaintiff's motion to require the defendant to elect between suicide and death caused by the beneficiary.

4. It was a contention of the plaintiff that the deceased was killed by a third person, suggested to be a burglar prowling about the house, and it is conceded if death was so caused there was liability under the policy. The court charged the jury that the burden of proving that death was so caused was upon the plaintiff. There can be no serious question of the correctness of this instruction. If death was so caused there was liability because it was death by accidental means. The burden of the issue was on the plaintiff. From the circumstances of Mr. McAlpine's death no presumption arose that he was killed by some third person. It was a matter of proof. What is said in the preceding paragraph upon the affirmative issue in the case and the burden of proof makes further discussion unnecessary.

5. We find no error in the rulings on the proposed testimony as to experiments made with the gun of the insured. The experiments sought to be shown were made by shooting against white paper. The plaintiff had given the result of other experiments with a substance furnishing a better illustration. The most that can be urged is that such testimony might have been received without error. It was properly and wisely excluded.

The court did not err in submitting to the jury whether the beneficiary was concerned with the death of the insured. The evidence was slight but not negligible.

We have examined all the contentions of the plaintiff. The trial was without error. It was conducted with entire fairness to the plaintiff. A new trial should not have been granted.

Order reversed.



ST. LOUIS COURT OF APPEALS.

MISSOURI.

LEMAITRE

vs.

NATIONAL CASUALTY CO. (No. 14413.)*

1. INSURANCE—EXTENT OF LIABILITY—ACCIDENT INSURANCE.

Where an accident policy provides for monthly indemnity for total disability and partial disability respectively and then for specific sums as indemnity for specific total losses, including the loss of a hand, where the insured suffered an accident in which he lost a hand and received other injuries causing a total disability for several months and partial disability thereafter for a time, and the indemnity for total and partial disability at the rates named in the policy exceeded the indemnity for the loss of a hand, insured is entitled to receive the indemnity for total and partial disability.

(For other cases, see Insurance, Cent. Dig. §§ 1310, 1311; Dec. Dig. §§ 524, 526.)

2. INSURANCE—ACCIDENT INSURANCE—NATURE OF CONTRACT.

A policy of accident insurance is not an exception to the rule that contracts of insurance are contracts of indemnity.

(For other cases, see Insurance, Cent. Dig. §§ 292, 296, 297; Dec. Dig. § 146[1].)

3. INSURANCE — CONTRACTS — CONSTRUCTION — CONFLICTING CLAUSES.

Where provisions in an accident policy for indemnity for total and partial disability respectively are followed by a provision for indemnity for specific total losses, if the two provisions are antagonistic, the first governs rather than the following.

(For other cases, see Insurance, Cent. Dig. § 294; Dec. Dig. § 146[2].)

4. INSURANCE—CONTRACTS—CONSTRUCTION IN FAVOR OF INSURED.

While contracts generally must be construed to make a harmonious whole, insurance contracts are to be interpreted most favorably to the insured.

(For other cases, see Insurance, Cent. Dig. § 295; Dec. Dig. § 146[3].)

* Decision rendered, June 6, 1916. 186 S. W. Rep. 964.

5. INSURANCE—ACTIONS—ATTORNEY'S FEE.

Whether the refusal of an insurance company to pay a claim on an accident policy is vexatious, authorizing an allowance of attorney's fee, is a question of fact for the jury, or for the trial judge where a jury is waived.

(For other cases, see *Insurance, Cent. Dig.* § 1498; *Dec. Dig.* § 602.)

Appeal from Circuit Court, City of St. Louis; Leo S. Rassieur, Judge. Action by Paul Lemaitre against the National Casualty Company. From a judgment for plaintiff, defendant appeals. Affirmed.

Leahy, Saunders & Barth and D. W. Voyles, all of St. Louis, for Appellant.
Walton & Senti, of St. Louis, for Respondent.

REYNOLDS, P. J.

This is an action on a policy of accident insurance instituted before a justice of the peace. The statement there filed, after formal averments, sets out the issue of the policy about October 21, 1907, and its renewal from time to time, and that it was in force at the time of the accident, it being on consideration of the payment of stated monthly premiums. The obligations assumed by defendant, as contained in clauses a and b of the policy, which clauses are hereinafter set out in full, are averred, and it is averred that about August 2, 1912, the policy being in full force and effect, plaintiff had received bodily injuries effected directly and independently of all other causes through external, violent and accidental means, and which immediately, continuously and wholly, from the date of the accident, did disable and prevent the assured from performing every duty pertaining to any business or occupation for a period of ten months and eight days, that is, from August 2, 1912, down to June 10, 1913, and that said injuries immediately following the period of total disability prevented the assured from performing one or more important daily duties pertaining to his occupation for a period of two months and ten days, that is, from June 10, 1913, down to August 19, 1913, and will continue to prevent plaintiff from performing one or more important daily duties pertaining to his daily occupation throughout his entire life. It is further averred that the injury resulted from plaintiff's right hand being caught in a belt revolving about a pulley, violently throwing plaintiff around the pulley, tearing his right arm from his body at or about the elbow joint and breaking his left arm in two places between the elbow and shoulder joint, fracturing four of plaintiff's ribs on the right side and bruising and injuring the left side of his head. Repeating the averments as to the injuries, and that they had prevented plaintiff from performing every duty pertaining to his occupation for a period of ten months and eight days and down to June 10, 1913, and that this period of total disability was followed by a period of partial disability caused by these injuries, beginning June 10, 1913, and lasting to the date of the filing of the petition,

to wit, August 20, 1913, it is claimed that in consequence of the total loss of time for a period of ten months and eight days, that is from the date of the accident down to June 10, 1913, defendant company became indebted to plaintiff under the terms of the policy in the sum of \$308, and that by reason of his partial disability for a period of two months and nine days, that is to say, from June 10 to August 19, 1913, defendant, under the policy, became indebted to plaintiff in the further sum of \$27.60, a total indebtedness of \$335.60. Averring a demand of the \$335, it is averred that defendant had vexatiously refused and still does vexatiously refuse to pay plaintiff that sum. Judgment is accordingly demanded for \$335.60, with interest from August 19, 1913, with 10 per cent damages thereon and \$125 attorney's fees because of the vexatious refusal on the part of defendant to pay.

There were no pleadings filed by defendant in the justice's court or in the circuit court, to which latter court the case was appealed and tried before the court, a jury being waived.

It appears that defendant tendered plaintiff \$150 as in full payment of all liability under this policy, being one-half of the principal sum of \$300 for loss of one hand by severance at or above the wrist joint, which plaintiff declined to receive.

There was evidence of the accident and its effect and duration, as set out in the petition or statement, of the demand for payment, refusal to pay and of the value of the attorney's services.

The policy sued on was given in evidence. It is recited in the policy that in consideration of the payment of the policy fee and of the premium and of the statements, etc., in the application being true, the defendant company insures plaintiff subject to the provisions and conditions contained in and indorsed upon the policy. The policy then proceeds as follows:—

"Accident Indemnity for Total Disability.

"(a) At the rate of thirty dollars per month against total loss of time not exceeding twenty-four consecutive months resulting from bodily injuries effected directly and independently of all other causes through external, violent and accidental means, and which immediately, continuously and wholly, from date of accident, disable and prevent the assured from performing every duty pertaining to any business or occupation.

"Partial Disability.

"(b) Or, if such injuries shall immediately, wholly and continuously, from date of accident, disable and prevent the assured from performing one or more important daily duties pertaining to his occupation, or in event of like disability immediately following total disability, or in event of total disability not immediately following injury, but within fifteen days of date of injury, the company will pay the assured for the period of such disability, not exceeding (6) consecutive months, two-fifths of the rate above specified for the total loss of time: Provided, the com-

bined period for which indemnity shall be paid for total and partial disability described in paragraphs (a) and (b) hereof shall not exceed twenty-four consecutive months.

"Specific Total Losses."

"(c) In event of any one of the following specific total losses which shall result from bodily injuries as described in paragraph (a) within ninety days from date of accident, the company will pay in lieu of any other indemnity:—

"For loss of Life (Payable to Beneficiary), Three Hundred Dollars	(The Principal Sum).
Both Hands, by severance at or above the wrist joint	The Principal Sum.
Both Feet, by severance at or above the ankle joint	The Principal Sum.
One Hand and One Foot, by severance at or above the said joints.....	The Principal Sum.
Entire Sight of Both Eyes, if irrecoverably lost	The Principal Sum.
Either Hand, by severance at or above the wrist joint	One-half of the Prin- cipal Sum.
Either Foot, by severance at or above the ankle joint	One-half of the Prin- cipal Sum.
Entire Sight of One Eye, if irrecoverably lost	One-third of the Prin- cipal Sum."

No declarations of law were asked or given.

The trial court entered up judgment against the defendant and surety for \$481.02, as follows:—

Principal policy sued on.....	\$335.60
Interest	11.86
Damages for vexatious refusal to pay	33.56
Attorney's fee	100.00

	\$481.02

From this, defendant filing a motion for new trial, has duly appealed to our court.

[1] It is contended by plaintiff below, and again in our court, that he is entitled to compensation as provided in clauses a and b of the policy, while defendant contends that plaintiff is entitled to compensation only as provided in clause c of the policy. The trial court adopting plaintiff's theory of the case, defendant assigns error to that action. It also assigns error in awarding and assessing damages for vexatious delay and in allowing counsel fees.

[2-4] The learned counsel for appellant argue that policies of accident insurance are, with policies of life insurance, exceptions to the rule that contracts of insurance are contracts of indemnity. We are unable to appreciate the force of this, either as a general principle or as applicable here. On the very face of the policy here involved and over clause a, which is the first clause providing for the payment of any sum, it is referred to as "accident indemnity for total disability," and throughout the policy, heading other clauses which are not here material and which we have not here quoted, it is referred to as a contract of indemnity. Thus, paragraph d is headed, "Double Indemnity," paragraph e, "Illness Indemnity," paragraph i is headed "Special Death Indemnity," paragraph j is headed "Quarantine Indemnity." Looking at this contract as a whole, construing it as a whole, it is very apparent that the main idea of it is indemnity, and the main feature in it is indemnity for loss of time in consequence of injury. Thus while the indemnity for injuries involving total loss of time, is set out in the very first paragraph of the policy (paragraph a) as at the rate of \$30 per month for not exceeding twenty-four consecutive months, which would give a total of \$720, the sum payable for certain specific losses is \$300. That is given for the loss of life, for the severance of both hands at or above the wrist, for the loss of both feet at or above the ankle joint, for the loss of one hand and one foot by severance at or above the joints, and the loss of entire sight of both eyes, if irrecoverably lost. Assuming that these clauses a and b are antagonistic to clause c, then the rule is, that the first is to govern rather than the following. *O'Connor vs. St. Louis American League Base Ball Co.*, 181 S. W. 1167. Applying that rule here, as we think it should be, and having regard to the fact that the policy itself by clauses a and b provide for total disability and partial disability specifically, and at a specified rate and precede clause c, which is for specific total losses, we think the construction that the learned trial court put upon this policy is correct. It is a rule of construction of all contracts that they must be so construed as to make a harmonious whole; but it is also a rule, particularly applicable to insurance contracts, that the interpretation most favorable to the insured is to be accepted. That is not from any prejudice against insurance companies, but because as is well known, the insurer prepares and dictates the terms of the policy and the insured has but little choice in its terms. He must take it or reject it as written by the insurer. Construing this policy on its face and having in mind what was probably most prominent in the mind of the insured, that is, to provide for loss of time in case of his disability and secure some compensation that would be immediately available to him, it would seem that he was more intent on weekly indemnity than on providing a fund available on his death. If the insured is to be remitted to the provision in clause c to \$300 in certain events, or to one-half,

or one-third of that in others, then what becomes of the distinct contract to pay so much a month for so many months when, as here, the latter would yield him \$335.60, or might yield him twenty-four times \$30, or \$720? In this view the contract would be one-sided, and so appellant's construction would make it. In short, appellant's contention would entirely eliminate the feature providing for weekly indemnity. That is not the way contracts of insurance are to be construed. To adopt any such would make this contract a delusion and a snare.

[5] We see no cause to differ from the learned trial judge in holding that the refusal to pay was vexatious. That is a question of fact under the statute for the determination of a jury, or, as here, of the trial judge, a jury being waived.

The judgment of the circuit court is affirmed.

Nortoni and Allen, JJ., concur.



SPRINGFIELD COURT OF APPEALS.

MISSOURI.

SCALES

v.s.

NATIONAL LIFE & ACCIDENT INS. CO. (No. 1660.)*

2. INSURANCE—LIFE INSURANCE—CONTRACTS—VALIDITY.

It is competent for the insurer and insured to contract for greater liability in case of death from certain causes than where it results from other causes or under different circumstances.

(For other cases, see Insurance, Cent. Dig. §§ 1309, 1316, 1317; Dec. Dig. § 530.)

3. INSURANCE—HEALTH AND ACCIDENT INSURANCE POLICY—VALIDITY.

Provisions in accident insurance policies, excepting certain classes and kinds of injuries and causes of death, are recognized as valid and binding contracts and provisions by the courts.

(For other cases, see Insurance, Cent. Dig. § 1171; Dec. Dig. § 451[1].)

4. INSURANCE—HEALTH AND ACCIDENT INSURANCE POLICY—VALIDITY.

A provision in an accident policy, providing for payment of only one-fifth the face of the policy for death by taking poison, does not cut down the amount of insurance, but is a mere clause for payment of a stipulated sum on happening of a certain event.

(For other cases, see Insurance, Cent. Dig. §§ 1309, 1316, 1317; Dec. Dig. § 530.)

* Decision rendered, May 25, 1916. 186 Southwestern Rep. 948.

**5. INSURANCE—HEALTH AND ACCIDENT INSURANCE POLICY
—VALIDITY.**

Rev. St. 1909, § 6945, as to conditions of policies on the question of suicide, makes absolutely void a clause, providing that only one-fifth the face of the policy is payable for death or disability due from injuries intentionally inflicted upon the assured by himself or by any other person, or from injuries inflicted upon the assured by himself or from injuries received by him while insane.

(For other cases, see Insurance, Cent. Dig. §§ 1309, 1316, 1317; Dec. Dig. § 530.)

**6. INSURANCE—HEALTH AND ACCIDENT INSURANCE POLICY
—VALIDITY.**

Such statute is intended to eliminate suicide as a defense to a life insurance policy, and was never intended to authorize a recovery of any amount, or to increase the amount of a policy because of suicide.

(For other cases, see Insurance, Cent. Dig. § 1153; Dec. Dig. § 445[2].)

**7. INSURANCE—HEALTH AND ACCIDENT INSURANCE POLICY
—VALIDITY.**

Where a policy for \$700 face value provided for one-fifth payment only, where death resulted from certain causes, including poisoning and suicide, and the insured committed suicide by taking poison, the beneficiary could not, by pleading the suicide, obtain the full face value, under Rev. St. 1909, § 6945, making void conditions as to suicide, but was entitled only to the one-fifth payment under the poison clause.

(For other cases, see Insurance, Cent. Dig. §§ 1309, 1316, 1317; Dec. Dig. § 530.)

Appeal from Circuit Court, Greene County; Guy D. Kirby, Judge.
Action by Maggie Scales against the National Life & Accident Insurance Company. Judgment for plaintiff, and defendant appeals. Reversed and remanded, with directions, and case certified to Supreme Court.

George Pepperdine and Patterson & Patterson, all of Springfield, for Appellant.

E. D. Merritt, of Springfield, for Respondent.

FARRINGTON, J.

The plaintiff (respondent) is the widow of William C. Scales and the beneficiary in a policy of life, accident, and illness indemnity insurance. The assured was found dead, having intentionally taken carbolic acid. The trial court, sitting as a jury, found that the assured committed suicide, and rendered a judgment for the principal sum of the policy, \$700, together with interest, from which defendant has appealed. Proof of death was furnished, and it is admitted by appellant and respondent that the only question presented here for decision is whether, under the terms of the policy and section 6945, R. S. 1909, the so-called suicide statute, the judgment rendered can be upheld.

[1] The St. Louis Court of Appeals, in the case of Applegate vs. Travelers' Insurance Co., 153 Mo. App. 63, 132 S. W. 2, ruled on this same question when presented in that case on a policy containing almost exactly the same provisions as are con-

tained in the one before us, and at the outset it may be well to say that we differ with our learned Brethren on the result therein reached, which, under section 6 of the Amendment of 1884 to article 6 of the Constitution, requires that we certify this cause to the Supreme Court for final determination.

The policy provided that the National Life & Accident Insurance Company of Nashville, Tenn., "does hereby insure William C. Scales, the person described in said schedule (hereinafter called the assured), subject to the provisions, conditions and limitations herein contained and indorsed hereon, from 12 o'clock noon, standard time, of the day this contract is dated until 12 o'clock noon, standard time, of the first day of January, 1910, and for such further periods, stated in the renewal receipts, as the payment of the premium specified in said schedule will maintain this policy and insurance in force, to wit," followed by several paragraphs which we will not set out in full. Paragraph (a) provides for "Total Accident Disability." Paragraph (b) provides for "Partial Disability." Paragraph (c) provides for "Specific Total Losses" as follows:—

"Or, if any one of the following specific total losses shall result solely from such injuries within ninety days from date of accident, the company will pay, in lieu of any other indemnity,

"For Loss of

"Life, five hundred dollars (the principal sum of this policy).
"Both hands by severance at or above wrist, the principal sum.
"Both feet by severance at or above ankle, the principal sum.
"One hand and one foot by severance at or above the wrist or ankle, the principal sum.

"Entire sight of both eyes, if irrecoverably lost, the principal sum.

"Either hand by severance at or above the wrist, one-half of the principal sum.

"Either foot by severance at or above the ankle, one-half of the principal sum.

"Entire sight of one eye, if irrecoverably lost, one-third of the principal sum.

"Indemnity for loss of life shall be payable to the beneficiary named in said schedule, if surviving; otherwise to the executors or administrators of the assured."

Paragraph (d) provides for "Double Indemnity." Paragraph (e) provides for "Illness Indemnity." Paragraph (f) provides for increased liability on certain paragraphs. Paragraph (g) provides for a 50 per cent accumulation on paragraph (c). Paragraph (h) provides for some special benefits in case of sunstroke, freezing, etc. Paragraph (i) provides for certain indemnity payable to the beneficiary. Paragraph (j) is as follows:—

"General Agreements.

"(j) In the event of injury or loss, fatal or otherwise, of which there shall be no external or visible mark on the body; or injury, fatal or otherwise, due wholly or in part, directly or indirectly, to disease or bodily infirmity; or injury, fatal or otherwise, or disability resulting directly or indirectly, from bodily infirmity, any gas, vapor, narcotic, anæsthetic or poison; or from rioting or strikes; or from exposure to obvious risks of injury or known danger; or death or disability due to or resulting, directly or indirectly, from injuries intentionally inflicted upon the assured by himself or by any other person, or from injuries inflicted upon the assured by himself, or received by him while insane; or while under the influence of any intoxicant or narcotic; or while attempting to evade arrest; or while violating law; or while violating the rules of a corporation, or the rules of a public carrier affecting the safety of its passengers; or while on the right of way, bridge, trestle, or other property of a railway corporation, other than stations, platforms and regular crossings prescribed by law, not being at the time passenger or employee of such railway in the discharge of duty, then and in all such cases referred to in this paragraph, the limit of the company's liability shall be one-fifth of the amount that would be otherwise payable under this policy, anything herein to the contrary notwithstanding. In the event of a loss hereinbefore particularly designated as a total loss, no claim shall exist for compensation other than that specifically provided for such total loss, and in no event shall the company be liable under paragraph (c) entitled 'Specific Total Losses,' for more than one of the losses named therein."

Paragraph (k) limits liability for certain kinds of disability. Paragraph (l) limits and eliminates liability when death or injury results from certain causes.

There are a number of other provisions in this policy, but enough have been referred to herein to show the many different kinds of liability and indemnity provided for, and the different amounts specified in case of different contingencies.

The time that the policy had been in force entitled the beneficiary to an increase of \$200 on the principal sum of the policy, if she was entitled to the principal sum for the death of her husband. The plaintiff's petition does not charge that the said assured's death resulted from the taking of poison with suicidal intent, but its charge of that matter is in the following language:

"Plaintiff further states that said William C. Scales died in Springfield, Mo., on the 17th day of October, 1914, and that said insurance so issued by said defendant was in full force and effect, with all premiums thereon paid at the date of said death."

The defendant in its answer alleged that under the terms of said policy in no event was the defendant liable on said policy for more than one-fifth of the face of the policy because of the

death of the assured other than where such death resulted "directly or independently of all other causes from bodily injuries effected through external, violent, and accidental means"; that the said "William C. Scales came to his death as the result of poison introduced into his system, and therefore under paragraph (j) plaintiff herein can only recover in accordance with said agreement," which fixed the recovery at \$140. The plaintiff's reply was as follows:—

"Comes plaintiff, and for reply to defendant's answer admits that the statement in said answer that said 'William C. Scales came to his death as the result of poison introduced into his system' is true, and plaintiff further alleges that said poison was introduced into the system of said William C. Scales by himself with suicidal intent, or, in other words, that said William C. Scales committed suicide, and that suicide was not contemplated at the time application was made for the policy sued on."

At the close of the evidence, which showed conclusively that the assured came to his death by intentionally taking carbolic acid for the purpose of committing suicide, the defendant requested two declarations of law, A and B. The giving of A and the refusal of B clearly reveals the theory on which the trial court rendered judgment for plaintiff in the sum of \$724.50, being the principal sum of the policy with interest to date of judgment. Declaration A, which was given, is as follows:—

"The court declares the law to be that, if it believes and finds from the evidence that death resulted to the insured W. C. Scales directly or indirectly from poison accidentally taken, then it will make a finding in favor of the plaintiff and fix the amount of her recovery at one-fifth of the face of the policy, to wit, one hundred forty dollars, together with interest thereon at the rate of 6 per cent per annum from October 17, 1914, to date."

Declaration B, which was refused, is as follows:—

"The court declares the law to be that, if it believes and finds from the evidence that death resulted to the insured, W. C. Scales, caused by taking carbolic acid, a poison, intentionally, then it will make a finding in favor of the plaintiff, to wit, one hundred forty dollars, together with interest thereon at the rate of 6 per cent per annum from October 17, 1914, to date."

[2, 3] It will be seen from the foregoing statement that the plaintiff brought suit for the principal sum named in the policy in case of loss of life by accident, and that the defense set up was that the assured died from the effects of poison, pleading the provision of the policy contained in paragraph (j) that in such event the company would only be liable for one-fifth of the principal sum of the policy. The plaintiff then pleaded suicide. From the declarations of law it is seen that the court tried the case on the theory that if the poison was accidentally taken by the assured, the provision in the policy placing liability at one-fifth of the principal sum, or \$140, would be operative, whereas, if

the poison was taken with suicidal intent the provision in the policy limiting the liability to \$140 was void under section 6945, R. S. 1909. The policy expressly provided that in the event of death by poison the company would pay a stipulated sum, and it is competent for insurer and assured to contract for an indemnity of one amount for death or injury resulting from certain causes, and a different amount for death or injury resulting from other causes or where the accident happens under certain designated circumstances. Provisions in accident insurance policies, excepting certain classes and kinds of injuries and causes of death, are recognized as valid and binding contracts and provisions by the courts of Missouri and elsewhere. *Meadows vs. Pacific Mut. L. Ins. Co.*, 129 Mo. 76, 31 S. W. 578, 50 Am. St. Rep. 427; *Hester vs. Fid. & Cas. Co.*, 69 Mo. App. 186; *Lovelace vs. Travelers' Pro. Ass'n*, 126 Mo. 104, 28 S. W. 877, 30 L. R. A. 209, 47 Am. St. Rep. 638; *McAndiless vs. Metropolitan L. Ins. Co.*, 45 Mo. App. 578; *Fetter vs. Fid. & Cas. Co.*, 174 Mo. loc. cit. 269, 73 S. W. 592, 61 L. R. A. 459, 97 Am. St. Rep. 560; *Crenshaw vs. Pacific Mut. L. Ins. Co.*, 71 Mo. App. loc. cit. 51, 52; *Brown vs. Supreme Lodge K. of P.*, 83 Mo. App. 633; *Mossop vs. Continental Cas. Co.*, 137 Mo. App. 399, 118 S. W. 680. See, also, 4 Cooley's Briefs on Ins. p. 3175. On page 3193 of the text last cited, under the same subject, in dealing with poison as an exception, we find the following rule deduced from the cases there cited:—

"Where the policy provides that the insurance shall not extend to death or disability caused 'by the taking of poison,' the exception includes cases where the poison was taken accidentally, as well as those where it was taken intentionally. *McGlother vs. Provident Mut. Acc. Co. of Philadelphia*, 89 Fed. 685, 32 C. C. A. 318; *Early vs. Standard Life & Acc. Ins. Co.*, 113 Mich. 58, 71 N. W. 500, 67 Am. St. Rep. 445; *Meehan vs. Traders' & Travelers' Acc. Co.*, 34 Misc. Rep. 158, 68 N. Y. Supp. 821; *Hill vs. Hartford Acc. Ins. Co.*, 22 Hun (N. Y.), 187; *Pollock vs. United States Mut. Acc. Ass'n*, 102 Pa. 230, 48 Am. Rep. 204."

See, also, *Shader vs. Railway Passenger Ass'n Co.*, 66 N. Y. loc. cit. 444, 23 Am. Rep. 65; *Campbell vs. Fid. & Cas. Co. of N. Y.*, 109 Ky. 661, 60 S. W. 492; *Standard Life & Acc. Ins. Co. vs. Jones*, 94 Ala. 434, 10 South. 530; 1 Cyc. 257; 1 Corpus Juris, 442, 455.

It has been held in the case of *Dezell vs. Fid. & Cas. Co.*, 176 Mo. 253, loc. cit. 292, 75 S. W. 1102, that a provision containing an exception against poison does not include the taking of medicine in good faith which contained poison. With this, however, we have nothing to do in this case, as the admitted facts are that the assured took the poison—carbolic acid—with suicidal intent. That case recognized the legality of making an exception as to poison, but turned on the construction of that provision.

[4] As we view this policy, the provision as to taking poison,

and other contingencies named in paragraph (j), is not a provision cutting down the amount of insurance, but is a clause providing for the payment of a specific amount on the happening of the contingencies therein named. It no more cuts down the clause where death occurs from accident due to violence than does the provision, contained in the policy, providing for a certain amount in case of partial disability, cut down the amount allowed for total disability, or the provision fixing the amount for the loss of one hand cut down the amount allowed for the loss of both eyes.

[5] The only application that section 6945, R. S. 1909, has to this policy is to make that clause in paragraph (j), providing, "or death or disability due to or resulting, directly or indirectly, from injuries intentionally inflicted upon the assured by himself or by any other person, or from injuries inflicted upon the assured by himself, or from injuries received by him while insane," absolutely void. *Tennent vs. Union Central L. Ins. Co.*, 133 Mo. App. 345, 112 S. W. 754; *Schmidt vs. Supreme Court United Order of Foresters*, 228 Mo. 675, 129 S. W. 653.

This insurance company doubtless writes insurance in a number of states wherein the provision against suicide is a valid provision, and it only becomes invalid by reason of our statute.

[6] As we view it, our statute is intended to eliminate suicide as a defense to this kind of policy, and was never intended to authorize a recovery of any amount, or to increase the amount of a policy because of suicide. It was not intended to give a cause of action; death furnishes the cause of action, and suicide, under our statute, is to be no defense to the liability fixed by death.

[7] Under the pleadings and declarations of law hereinbefore set out, the fact that intentional death was pleaded by the plaintiff and proven by the plaintiff furnished a cause of action to the plaintiff for \$700, whereas had not the suicide been pleaded and proven, the liability under this policy would not have exceeded \$140. It is said that while the defendant does not specifically plead suicide as a defense, by pleading this exception it in effect obtained the advantage or benefit of the defense of suicide. To this we cannot agree. The plaintiff had no cause of action for \$700 under this policy because the admissions made in the pleadings show that Scales was not insured for \$700 if he died from the effects of taking poison; and, had plaintiff's petition been filed to enforce the contract which inured to her benefit, she would then have sued for \$140, and the defendant would not have been permitted, on account of the statute, to answer that it was relieved by reason of the suicide. The provision in the policy was not confined to poison taken with suicidal intent; it includes all cases where death results from poison qualified by the rule announced in the case of *Dezell vs. Fid. & Cas. Co.*, supra, and cannot be said to have been inserted in order to avoid the statute. This appears from the fact that an exception, limiting the amount

recoverable to the same amount if the assured commits suicide, is contained within the same paragraph.

The respondent relies principally on the case of Applegate vs. Travelers' Insurance Co., 153 Mo. App. 63, 132 S. W. 2, and the case of Whitfield vs. Aetna L. Ins. Co., 205 U. S., 489, 27 Sup. Ct. 578, 51 L. Ed. 895. The court in the Applegate Case bases its decision on the Whitfield Case. As stated in the beginning, we are unable to distinguish our case from the Applegate Case. We think there is a distinction between the Whitfield Case and the Applegate Case, and that the same distinction exists between our case and the Whitfield Case, and that this distinguishing feature, in our judgment, would have been sufficient basis for a different result in the Applegate Case. In the Whitfield Case the defense was based on an exception in case of suicide, and the court held, under the authorities therein cited, that the Missouri statute pertaining to suicide rendered the provision in the policy void. This is indisputable. As to what the court was deciding in that case will be found at page 496 of 205 U. S., at page 580 of 27 Sup. Ct., and near the bottom of page 898 of 51 L. Ed., where the court, before beginning a discussion of the question, used this language:—

"Will the statute, in a case of suicide, allow the company, when sued on its policy, to make a defense that will exempt it, simply because of such suicide, from liability for the principal sum?"

All that was really decided in that case relevant to the question before us was that our statute against suicide being used as a defense is applicable whether it is invoked as a total or a partial defense. This is clearly shown by that case in its various steps leading to the Supreme Court of the United States, when it was first decided in (C. C.) 125 Fed. 269, and next in 144 Fed. 356, 75 C. C. A. 358. Neither the Whitfield Case nor any of the following cases cited by respondent (Berry vs. Knights Templars' & Masons' Life Ind. Co. [C. C.] 46 Fed. 439; Knights Templars' & Masons' Life Ind. Co. vs. Jarman, 187 U. S. 197, 23 Sup. Ct. 108, 47 L. Ed. 139; Logan vs. Fid. & Cas. Co., 146 Mo. 114, 47 S. W. 948; Keller vs. Travelers' Ins. Co., 58 Mo. App. 557; Christian vs. Connecticut Mut. L. Ins. Co., 143 Mo. 460, 45 S. W. 268; Schmidt vs. Supreme Court Order of Foresters, 228 Mo. 675, 129 S. W. 653; Knights Templars' & Masons' Life Ind. Co. vs. Berry, 50 Fed. 511, 1 C. C. A. 561) hold that where a policy limits payment of a certain amount in case of a certain cause of death, the suicide statute can be used as a force to lift a cause of action out of one paragraph and into another paragraph of the policy by showing that the death resulted from the cause being intentionally inflicted. The holding in the Whitfield Case on the Missouri statute concerning suicide, the opinion in which discusses at length the purpose of the statute in the light of Missouri decisions, is as follows:—

"The manifest purpose of the statute was to make all inquiry

as to suicide wholly immaterial, except where the insured templated suicide at the time he applied for his policy."

It would seem against all public policy to allow an insurance company to insure the lives of only such persons as commit suicide, and this is intimated in the case of *Ritter vs. Mutual Ins. Co.*, 169 U. S. 139, 18 Sup. Ct. 300, 42 L. Ed. 693. The policy provides that if the injury when fatal results from or indirectly from poison the amount of indemnity shall be held up to hold that the company will be bound to pay \$140 if the poison is taken accidentally, and that it must pay \$700 if the poison, taken with suicidal intent, is in effect holding that a policy taking a premium on suicide, and giving suicide as a preferred method of action is a legal and valid agreement. We are of the opinion that our suicide statute was intended to merely cut off one way of defense formerly in the hands of insurers, and was never intended to create a cause of action upon affirmatively showing suicide as a cause of the death.

It seems to us there is a vast difference between holding other suicide, under our statute, cannot be made by contract a partial defense or be used to reduce the recovery and holding that competent for an insurance company to provide an indemnity of \$140 where death results from poison howsoever taken. To illustrate: Suppose a policy provided an indemnity of \$5,000 in the event of death resulting from a gunshot wound and \$500 in death results from poison and contained a clause against suicide; and the policy only provided for these two classes. Now, though suicide by shooting could not be shown to defeat or increase the first amount, could it be contended that because suicide was committed by taking poison the beneficiary could recover \$5,000 by reason of the statute? This would be a very different case from one in which the policy contained a provision to pay \$5,000 if death resulted from a gunshot wound, but only \$500 if the wound was inflicted for the purpose of committing suicide. The mere fact of suicide would not, in and of itself, create greater liability than if death resulted unintentionally from the same circumstances and from the same cause.

Under the pleadings in this case the plaintiff was entitled to a judgment for \$140. Therefore, the judgment is reversed, and the cause remanded, with directions to the circuit court to enter a judgment in accordance with this opinion. However, as the opinion we have rendered is in conflict with that of the St. Louis Court of Appeals in the Applegate Case, supra, the cause is certified to the Supreme Court for final determination.

Robertson, P. J., and Sturgis, J., concur.

here the issue was whether the defendant's policy covered the plaintiff's condition. The court held that it did not, and allowed an appeal by the plaintiff. The case is reported as *Foster vs. North American Accident Ins. Co.* (No. 30831.)*

(Supreme Court of Iowa.)

Ed. 693. INSURANCE—PROXIMATE CAUSE OF INJURY—EVIDENCE. Plaintiff brought suit against defendant for \$140, claiming that he had sustained a verdict that plaintiff's paralytic condition was caused by being jolted against the top of an automobile and falling back onto a surgical case in the bottom of the machine. Plaintiff had been a passenger in the car. In other cases, see Insurance, Cent. Dig. §§ 1719, 1721, 1722; Dec. Dig. § 665[5].

INSURANCE—EXTENT OF INSURER'S LIABILITY—ACCIDENT INSURANCE—LIMITATION BY POLICY.

Insurance policy's limitation of liability as to "disability, due to either accident or illness, resulting wholly or in part directly or indirectly, from * * * paralysis," applies where a disability results from paralysis, but not where an accident results in paralysis.

In holding other cases, see Insurance, Cent. Dig. §§ 1309, 1316, 1317; Dec. Dig. § 530.)

Appeal from District Court, Lee County; W. S. Hamilton, Judge. Action at law upon a policy of accident insurance issued by defendant to the plaintiff. Upon the issues joined the case was tried to a jury, resulting in a verdict for plaintiff in the sum of \$819. Defendant appeals.

Edward St. Clair, of Chicago, Ill., and Craig & Sprowls, of Keokuk, Appellant.

Hollingsworth & Blood, of Keokuk, for Appellee.

* Decision rendered, June 24, 1916. 158 N. W. Rep. 401.

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COLLOPY vs. MODERN BROTHERHOOD OF AMERICA.

(No. 19852 [203].)*

(Supreme Court of Minnesota.)

1. INSURANCE—ACTIONS ON POLICIES—LIMITATIONS—ACCRUAL OF CAUSE OF ACTION.

The certificate issued by defendant, a fraternal beneficiary society, provided for: (1) The payment of a certain sum to plaintiff's widow upon his death; (2) the payment of a certain sum to him in case of an accidental injury causing the fracture of a limb or the loss of a hand, foot or eye; (3) the surrender of the certificate and payment to him of one-half of the death benefit in case of permanent and total disability; and (4) payments to him of the same amount payable in case of death in ten annual installments, beginning on his seventieth birthday.

* Decision rendered, June 30, 1916. 158 N. W. Rep. 625. Syllabus by the Court.

first birthday, if he was then physically disabled. This action was brought under the third provision. It is *held*:
The statute of limitations does not bar plaintiff's cause of action, since it did not accrue upon the mere occurrence of plaintiff's permanent and total disability, but only upon his election thereafter to take under the third provision, make a demand therefor present defendant with sufficient proof of his right thereto, and upon defendant's wrongful rejection of the demand.

(For other cases, see Limitation of Actions, Cent. Dig. § 359; Dec. Dig. § 66[6]; Action, Cent. Dig. § 708.)

Appeal from District Court, Washington County; P. H. Stolberg, Judge.

Action by George Collopy against the Modern Brotherhood of America. From an order denying a motion for judgment notwithstanding the verdict or a new trial, defendant appeals. Affirmed.

Comfort & Comfort, of Stillwater, and Sparrow & Page, of Kansas City, Mo., for Appellant.

Wilson & Thoreen and Geo. H. Sullivan, all of Stillwater, for Respondent.



SYKES *vs.* ROYAL CASUALTY CO. (No. 18178.)*

(Supreme Court of Mississippi, Division B.)

INSURANCE — ACCIDENT INSURANCE — AGREEMENT FOR ARBITRATION—WAIVER.

In an action on a policy of accident insurance, which contained a clause providing for arbitration in case of dispute over any claim under the policy, and the usual clause providing that no suit shall be brought on the policy under sixty days from date of final proof, arbitration clauses being put in insurance policies wholly for the protection of the insurer, in view of the fact that no suit could be maintained until sixty days had elapsed from date of final proof, the insurer by not requesting an arbitration before suit was brought waived its right to arbitration.

(For other cases, see Insurance, Cent. Dig. § 1436; Dec. Dig. § 576[1].)

Appeal from Circuit Court, Monroe County; Claude Clayton, Judge.
Suit by T. B. Sykes against the Royal Casualty Company. From a judgment of the circuit court dismissing the case on appeal by defendant from a judgment of justice court for plaintiff, plaintiff appeals. Reversed and remanded.

Sykes & Sykes, of Aberdeen, for Appellant.
Paine & Paine, of Aberdeen, for Appellee.

* Decision rendered, June 26, 1916. 72 South. Rep. 147.

CASUALTY, SURETY AND MISCELLANEOUS.**SUPREME COURT OF NEW YORK.
APPELLATE TERM, FIRST DEPARTMENT.****STICH****vs.****FIDELITY & DEPOSIT CO. OF MARYLAND.*****1. INSURANCE—ACTION ON THEFT POLICY—FELONIOUS ABSTRACTION—PRESUMPTION—RES IPSA LOQUITUR.**

In an action upon a burglary insurance policy, by the express terms of which the company's liability depended upon proof of "felonious abstraction," such an abstraction could not be presumed or inferred from a mere loss.

(For other cases, see Insurance, Cent. Dig. §§ 1659-1662, 1664; Dec. Dig. § 646[6].)

2. INSURANCE—ACTION ON POLICY—SUFFICIENCY OF EVIDENCE.

In such action, evidence that rings were placed in a hotel room in a box which only two persons were authorized to open, and that neither of these took them, but they were missing, showed a probable abstraction by an unauthorized person with felonious intent, or a "felonious abstraction."

(For other cases, see Insurance, Cent. Dig. § 1722; Dec. Dig. § 665[4].)

Appeal from Municipal Court, Borough of Manhattan, First District.

Action by John Stich against the Fidelity & Deposit Company of Maryland. From a judgment of the Municipal Court, and from an order denying a new trial, defendant appeals. Affirmed.

Argued March term, 1916, before Lehman, Pendleton, and Whitaker, JJ.

Walter G. Evans, of New York City (Walter R. Kuhn, of Brooklyn, of counsel), for Appellant.

H. J. Goldsmith and F. E. Goldsmith, both of New York City, for Respondent.

LEHMAN, J.

[1, 2] The plaintiff can recover only if he shows that the loss of the jewelry insured occurred by "burglary, theft, or larceny." By the express terms of the policy the insurance company is not liable unless the loss is occasioned by "felonious abstraction." A felonious abstraction cannot be presumed, nor can it be inferred from a mere loss. Where the evidence is entirely consistent with a loss by negligence of the party insured or by the innocent act of

* Decision rendered, May 31, 1916. 159 N. Y. Supp. 712.

a third party, the plaintiff has obviously failed to prove a loss by felonious abstraction. In the cases of Schindler vs. United States Fidelity & Guaranty Co., 58 Misc. Rep. 532, 109 N. Y. Supp. 723, and Gordon vs. \textcircumflex tina Indemnity Co., 116 N. Y. Supp. 558, the court held that the evidence there presented was not sufficient to show such felonious abstraction. The evidence there showed a loss or disappearance, but that loss or disappearance was not shown to have occurred under circumstances so inconsistent with an innocent disappearance as to fairly raise the inference that the loss was due to felonious abstraction. The court did not there hold that proof of disappearance might not be sufficient to show a felonious abstraction, if the circumstances surrounding the disappearance were not reasonably consistent with disappearance through an innocent cause.

The contract in this case contains no clause providing that a felonious abstraction must be shown by direct evidence, and the court has no right to make such a contract for the parties. In this case the trial judge has held that the circumstantial evidence shows a felonious abstraction, and if the plaintiff's evidence is sufficient to raise an inference to this effect we must affirm the judgment. The plaintiff's evidence shows that his wife placed two diamond rings in a Japanese box. The box was placed in a drawer, and the key to the drawer was hidden under some clothes. No one but the plaintiff's wife and daughter knew where the key was placed. A few days after the diamond rings were placed in the box, the plaintiff's wife looked for them, and they were not in the box. Neither the plaintiff's wife nor daughter had taken them out. The box contained other jewelry, but the missing rings were the only articles of value. The plaintiff and his family occupied rooms in a hotel, and various employees of the hotel had access to the rooms.

This testimony for the plaintiff was not directly contradicted, and the trial justice has weighed the credibility of the story, and has believed it. Upon this appeal the only serious question is whether this testimony justifies the inference that the jewelry was stolen. It establishes that the jewelry was placed in a box which only two persons were authorized to open. Neither of these persons took out the jewelry. It follows with reasonable probability that some unauthorized person opened the box and extracted the only articles of value. No unauthorized person would have taken the jewelry, except with felonious intent.

It follows that the judgment rests, not on mere suspicion, but on logical inference, and should be affirmed, with \$25 costs. All concur.

SUPREME COURT OF NEW YORK.

APPELLATE TERM, FIRST DEPARTMENT.

CHRISTATOS

vs.

NEW ENGLAND CASUALTY CO.*

1. INSURANCE — INDEMNITY INSURANCE—CONDITION — CONSTRUCTION.

Where a storekeeper's indemnity insurance policy is conditioned by a requirement that the insured give immediate notice of any accident to defendant, and give like notice of any claim being made on account of the accident, such condition means that insured shall give immediate notice after he has become apprised of the accident, or would have become apprised, had he exercised reasonable diligence.

(For other cases, see Insurance, Cent. Dig. § 1329; Dec. Dig. § 539[3].)

2. INSURANCE—INDEMNITY INSURANCE—DUTY OF INSURED.

A storekeeper carrying indemnity insurance, conditioned that he give immediate notice to the insurer of any accident, is under duty to so regulate his business that he may be apprised with reasonable certainty of any accident that may occur in its conduct.

(For other cases, see Insurance, Cent. Dig. § 1329; Dec. Dig. § 539[3].)

3. INSURANCE—INDEMNITY INSURANCE—OBLIGATION OF INSURED.

Where, despite the exercise of reasonable care, a storekeeper carrying indemnity insurance fails to acquire knowledge of an accident until after a lapse of time, but, upon its acquisition, he promptly notifies the insurance company, he complies with his obligation under the policy to give immediate notice.

(For other cases, see Insurance, Cent. Dig. § 1329; Dec. Dig. § 539[3].)

4. INSURANCE — INDEMNITY INSURANCE — COMPLIANCE WITH CONDITION OF POLICY—SUFFICIENCY OF EVIDENCE.

In an action on a storekeeper's policy of indemnity insurance, evidence as to whether insured notified insurer of an accident promptly after he or his representatives learned of it, as required by the policy, held not to support verdict for plaintiff.

(For other cases, see Insurance, Cent. Dig. §§ 1723, 1724, 1726, 1727; Dec. Dig. § 665[7].)

Appeal from City Court of New York, Trial Term.

Action by Nicholas Christatos against the New England Casualty Company. From a judgment for plaintiff, defendant appeals. Judgment reversed, and new trial ordered.

Argued June term, 1916, before Guy, Bijur, and Philbin, JJ.

* Decision rendered, June 22, 1916. 159 N. Y. Supp. 700.

James I. Cuff, of New York City, for Appellant.

Albert I. Sire, of New York City (Bennett E. Siegelstein and William L. Stone, both of New York City, of counsel), for Respondent.

GUY, J.

[1-3] Plaintiff has recovered a judgment against defendant, insurer on a policy of accident insurance. It appears that on or about July 5, 1913, one O'Brien was injured accidentally in plaintiff's store; that one year afterwards, in July, 1914, plaintiff, having had no notice of the accident, as he claims, was served with a summons in an action brought against him by O'Brien to recover damages for the injuries; that plaintiff thereupon notified the defendant of the suit, but that defendant's attorney claimed that, because of the failure of the insured to give the insurer immediate notice, it was not liable on the policy; that plaintiff accordingly retained counsel for the trial of the accident case, in which judgment was recovered for \$150; and this action is on the policy to recover for the amount paid in satisfaction of that judgment and also for reasonable counsel fees.

The defense is that plaintiff failed to perform the condition of the policy requiring him to give immediate notice of the accident to the defendant, and in the event of a claim being made on account of the accident to give like notice of such claim. The condition of the policy is to be interpreted as meaning that the insured shall give immediate notice after the insured has become apprised of the accident, or should have become so apprised, had he exercised reasonable diligence. There is therefore cast upon him the duty of so regulating his business that he may be apprised with reasonable certainty of any accident that may occur in its conduct. If, despite the exercise of reasonable care, the insured fails to acquire the information till after a lapse of time, but on its acquisition gives prompt notice to the insurance company, he complies with the obligation of the policy. *Woolverton vs. Fidelity & Casualty Co.*, 190 N. Y. 41, 47, 48, 82 N. E. 745, 16 L. R. A. (N. S.) 400.

[4] O'Brien, the injured man, identified plaintiff's manager, Ezechel, in court as having been present at the time of the accident, and having been present when O'Brien was picked up by two other men who were in the store at the time, and testified that he remained in the store for five minutes, then limped out of the store, accompanied by one of plaintiff's clerks, and that plaintiff's manager, Ezechel, came over to the place where plaintiff fell. Ezechel, called as a witness by plaintiff, denied absolutely having any knowledge as to the happening of the accident; but, when cross-examined as to testimony given by him on a former trial in which O'Brien was plaintiff, admitted testifying that he remembered seeing plaintiff leave the store wth somebody from the store, and that when that person came back he asked for what reason he left the store with O'Brien, and that he

replied that the boy scratched himself; and when on said former trial he was asked the question, "Q. Then you did know something about this thing having happened?" he answered, "A. Surely." In view of these admissions as to what he testified to on a former trial, Ezechel's denial of knowledge of the happening of the accident was entirely unworthy of credence, and the jury were not justified in basing a verdict on such denial. There is, however, further uncontradicted evidence of actual notice of the happening of the accident given to plaintiff's representative in charge of his business on July 9th, four days after the accident, and again on July 24, 1913, and that plaintiff's son opened the letter of July 24th, and replied thereto on the letterhead of the plaintiff on July 29th.

Plaintiff's son, called as a witness by plaintiff, admitted that one of these letters was opened by him and answered by him, and that he had authority to open the mail during his father's absence in Europe. These letters would constitute, under the law of the case as laid down in the charge made by the trial judge to the jury, sufficient notice to plaintiff of the happening of the accident to O'Brien to render it obligatory upon plaintiff, under the terms of the policy of insurance, to give immediate notice thereof to the company. In finding in favor of the plaintiff the jury have not only given undue credence to the denial by plaintiff's manager of knowledge of the happening of the accident, which denial was entirely discredited by admissions made upon a former trial, but have utterly disregarded the proof of written notice addressed to plaintiff at plaintiff's place of business shortly after the happening of the accident, whereby those left by plaintiff in charge of plaintiff's business became possessed of knowledge of the happening of the accident. The verdict of the jury, therefore, was against the overwhelming weight of evidence, and cannot be allowed to stand.

The judgment must therefore be reversed, and a new trial ordered, with costs to appellant to abide the event. All concur.



**EMPLOYERS' LIABILITY ASSUR. CORP., LTD., vs. JONES
COUNTY LUMBER CO. (No. 18385.)***

(Supreme Court of Mississippi, Division B.)

1. INSURANCE — LIABILITY INSURANCE — NOTICE OF INJURIES—KNOWLEDGE OF EMPLOYER.

Where a lumber company's injured employee resumed work, not submitting any claim, no other servant notifying the management of the injury, and waited two years before he instituted his action against it,

* Decision rendered, June 26, 1916. 72 South. Rep. 152.

the company, being without knowledge, was under no duty to report the accident to its insurer, in accordance with a clause of the policy requiring that upon occurrence of an accident involving bodily injuries or death assured should give immediate written notice to the insurer's home office.

(For other cases, see Insurance, Cent. Dig. § 1334; Dec. Dig. § 539[6].)

2. INSURANCE—LIABILITY INSURANCE—DELAY IN GIVING NOTICE OF SUIT—EFFECT.

Where an employer, insured against liability for injuries to its employees, delayed to give notice to the insurer of filing of its injured employee's suit from April 18 to June 17 and 19, the Court convening June 23 and the case being tried June 27 and 28, the insurer having attorneys resident eight miles from the place of trial, the delay in giving notice of the suit did not bar the employer's recovery on its policy; since the requirement of prompt notice is not of the essence of the contract, unless it materially affects the rights of the parties in the particular case.

(For other cases, see Insurance, Cent. Dig. §§ 1333, 1335, 1336; Dec. Dig. § 539[5].)

Appeal from Circuit Court, Forrest County; Paul B. Johnson, Judge. Action by the Jones County Lumber Company against the Employers' Liability Assurance Corporation, Limited. From a judgment for plaintiff, defendant appeals. Affirmed.

Deavours & Hilbun, of Laurel, for Appellant.
Tally & Mayson, of Hattiesburg, for Appellee.



COMMERCIAL BANK *vs.* MARYLAND CASUALTY CO. (No. 1766.)*

(Springfield Court of Appeals. Missouri.)

2. INSURANCE—CONTRACTS—CONSTRUCTION.

The contract of a surety company executing its fidelity bond for a consideration must be construed most strictly in favor of the obligee.

(For other cases, see Insurance, Cent. Dig. § 295; Dec. Dig. § 146[3].)

3. INSURANCE—FIDELITY BOND—APPLICATION—MISREPRESENTATIONS.

In an application by the president of a bank for a bond for an employee, the answer to a question whether he was indebted to the officers of the bank that he was indebted to about \$3,500 on personal indorsements, and the answer to the question whether he was interested in any other business that he owned a motor car company, without stating that he owned a motion picture business, and the answer that, so far as the president knew, he had always faithfully accounted for all moneys in his custody and had proper funds on hand to balance accounts, were

* Decision rendered, May 25, 1916. Rehearing denied, June 24, 1916.
187 S. W. Rep. 103.

not misrepresentations, where they were made in good faith, and where it appeared that the balance was sometimes "long" and sometimes "short," and that such items were clerical errors which were from time to time straightened up, and that his balance was "long" when the answer was made.

(For other cases, see Insurance, Cent. Dig. § 657; Dec. Dig. § 285.)

Appeal from Circuit Court, New Madrid County; Sterling H. McCarty, Judge.

Action by the Commercial Bank against the Maryland Casualty Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Oliver & Oliver, of Cape Girardeau, for Appellant.

John A. Hope, of St. Louis, and Riley & Riley, of New Madrid, for Respondent.



COMMERCIAL BANK *vs.* AMERICAN BONDING CO.

(No. 1765.)*

(Springfield Court of Appeals. Missouri.)

2. INSURANCE—FIDELITY INSURANCE—STATUTE.

Rev. St. 1909, § 7024, relating to the construction of warranties of fact, section 7026, forbidding the evasion of provisions relating to warranties, etc., and section 6937, providing that no misrepresentation made in obtaining a policy of life insurance shall be deemed material to render the policy void unless the representation shall have actually contributed to the contingency on which it is payable, do not cover fidelity bonds.

(For other cases, see Insurance, Cent. Dig. § 539; Dec. Dig. § 250[1].)

3. INSURANCE—CONTRACT—WARRANTY.

A warranty is a parcel of the contract, and must be absolutely true, whether material to the risk or not.

(For other cases, see Insurance, Cent. Dig. § 567; Dec. Dig. § 267.)

4. INSURANCE—RENEWAL—CONSTRUCTION OF CONTRACT.

A renewal of a policy or bond constitutes a separate and distinct contract for the period covered thereby, and, where the renewal receipt recites a renewal in accordance with the terms of the bond, it is a contract with the same terms as evidenced by the bond renewed.

(For other cases, see Insurance, Cent. Dig. §§ 276, 278-283, 287-291; Dec. Dig. § 145[1].)

5. INSURANCE—FIDELITY BOND—RENEWAL—WARRANTIES.

The original warranties run through any renewal of a fidelity bond, and the insurer, in case demand is made on it under the terms of the contract, may show that any statements in the original application made for the bond were untrue; but this does not mean that such statements are promissory covenants or warranties which will render the bond

* Decision rendered, May 25, 1916. Rehearing denied, June 24, 1916.
187 S. W. Rep. 99.

void if the conditions existing between the employee and the insured have become changed.

(For other cases, see Insurance, Cent. Dig. §§ 276, 278-283, 287-291; Dec. Dig. § 145[1].)

6. INSURANCE—FIDELITY BOND—RENEWAL RECEIPT—REPRESENTATION.

Where a bonding company, issuing a renewal receipt, required the statement from the insured asserting that the employee had faithfully and honestly accounted for all moneys and property and always had sufficient securities on hand to balance his accounts, and was not then in default, which statement was not made a warranty by any of the terms of the contract, the statements were only representations, and not warranties.

(For other cases, see Insurance, Cent. Dig. § 560; Dec. Dig. § 265.)

7. INSURANCE—"REPRESENTATIONS"—EFFECT.

Representations are not a part of the contract in the sense that warranties are, but are inducements to a contract, though not facts which are contracted to be true, and they do not have to be literally true, as do warranties.

(For other cases, see Insurance, Cent. Dig. §§ 538-542; Dec. Dig. § 253.)

(For other definitions, see Words and Phrases, First and Second Series, Representation.)

8. INSURANCE—FIDELITY INSURANCE—REPRESENTATION—EFFECT.

A representation in the renewal receipt of a fidelity bond that the employee was not in default was a representation material to the risk, and which if falsely or fraudulently made would avoid the contract.

(For other cases, see Insurance, Cent. Dig. § 548; Dec. Dig. § 255.)

9. INSURANCE—FIDELITY BOND—REPRESENTATIONS.

In the case of a representation, although material to the risk, if made in good faith, its falsity will not render the contract induced thereby void or voidable.

(For other cases, see Insurance, Cent. Dig. § 540; Dec. Dig. § 256[2].)

10. INSURANCE—FIDELITY BOND—RENEWAL CONTRACT—REPRESENTATIONS.

Where a fidelity bond provided that all representations made by the employer to the surety were warranted to be true, the employer's statements or representations on the issuance of a renewal receipt that the employee had not to the knowledge of the employer been in default in the position covered by the bond and a renewal receipt, and had faithfully accounted for all moneys in his custody, and was not in default, made when none of the officers of the insured bank knew, or had any reasonable ground for knowing, that the employee was in default, were not made recklessly, but in the honest belief that they were true, and their untruth would not defeat the renewal bond.

(For other cases, see Insurance, Cent. Dig. 540; Dec. Dig. § 256[2].)

Appeal from Circuit Court, New Madrid County; Sterling H. McCarty, Judge.

Action by the Commercial Bank against the American Bonding Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Everett Reeves, of Caruthersville, for Appellant.
John A. Hope, of St. Louis, and Riley & Riley, of New Madrid, for Respondent.

LOMBARD vs. MAGUIRE-PENNIMAN CO. ET AL.
(No. 1311.)*

(Supreme Court of New Hampshire. Strafford.)

2. INSURANCE—INDEMNITY INSURANCE—LIABILITY OF INSURERS TO INJURED PARTY.

Indemnity insurers who had agreed that, if they assumed the defense of a suit to recover for a loss covered by the policy, they would either pay the insurer the indemnity or secure release of insured from the claim, but who failed to do either, after assuming a defense, were liable to insured in assumpsit without the latter first paying the injured party's claim, and in an action by the injured party against insured they were chargeable as trustees with the amount of the indemnity.

(For other cases, see Insurance, Cent. Dig. § 1298; Dec. Dig. §514.)

Transferred from Superior Court, Strafford County; Chamberlin, Judge.

Suit by Sadie J. Lombard, Administratrix, against the Maguire-Penniman Company and trustees. Question of the trustees' chargeability transferred without ruling. Trustees chargeable.

Trustee process. The plaintiff brought a suit against the defendants to recover for the death of her intestate. The liability was one against which the trustees had insured the defendants, and they assumed the defense of the suit. The plaintiff recovered judgment, but the trustees have neither paid the defendants the indemnity to which they were entitled under the policy nor secured their release from the plaintiff's claim. The defendants failed to pay the plaintiff's judgment, and she brought this suit and summoned the insurance company as trustees. The question of their chargeability was transferred by Chamberlin, J., without a ruling.

Hughes & Doe, of Dover, for Plaintiff.
Jones, Warren, Wilson & Manning, of Manchester, for Trustees.

* Decision rendered, Feb. 1, 1916. 97 Atl. Rep. 892.

NATIONAL SURETY CO. vs. BREUCHAUD.*

(New York Supreme Court, Appellate Division, First Department.)

2. INSURANCE—COUNSEL FEE—"BY REASON OF SURETYSHP."

A counsel fee paid by a surety company in its action to recover the first installment of the premium on its bond was not an expense arising "by reason of such suretyshp." within the agreement that the in-

* Decision rendered, July 10, 1916. 160 N. Y. Supp. 77.

demanitor would save the surety harmless against every claim, liability, cost, etc., "against it by reason of suretysip," so that in defendant's action to recover the second installment of the premium the surety could not recover the counsel fee paid in the first.

(For other cases, see Insurance, Cent. Dig. §§ 465-467; Dec. Dig. § 198[6].) (For other definitions, see Words and Phrases, First and Second Series, By Reason of.)

Appeal from Trial Term, New York County.

Action by the National Surety Company against Jules Breuchaud. From a judgment for plaintiff, defendant appeals. Judgment reduced, and, as modified, affirmed.

Argued before Clarke, P. J., and McLaughlin, Scott, Smith, and Page, JJ.

Vance Hewitt, of New York City, for Appellant.

William R. Page, of New York City, for Respondent.

LIFE.

UNITED STATES CIRCUIT COURT OF APPEALS.

THIRD CIRCUIT.

AMERICAN TEMPERANCE LIFE INS. ASS'N or CITY OF NEW YORK

vs.

SOLOMON ET AL. (No. 2073.)*

1. INSURANCE—LIFE INSURANCE—ACTIONS—JURY QUESTIONS.

In an action on a life policy, where the defense was insured's false answers to questions in the application as to his age, use of intoxicating liquors, and rejection of any previous application for insurance, the court properly decided as a matter of law that answers to such questions were material to the risk, but left to the jury the question whether the answers given were false.

(For other cases, see Insurance, Cent. Dig. §§ 1737-1740, 1758-1760; Dec. Dig. § 668[6].)

2. INSURANCE—LIFE INSURANCE—EVIDENCE—MATERIALITY

Where the application for a life policy denied that insured had ever been rejected by any other company, the question whether insured could read or write is immaterial on the question of the binding force of the representation; but, in determining whether insured applied for a policy in another company, the question whether he could read or write, and so understood that an agent was making application for him in a different company, is material.

(For other cases, see Insurance, Cent. Dig. §§ 1677, 1680, 1681, 1685; Dec. Dig. § 655[2].)

In error to the District Court of the United States for the Western District of Pennsylvania; Charles P. Orr, Judge.

Action by Louis Solomon and others, administrators of the estate of Max Solomon, deceased, for the use of Louis Solomon, and others, against the American Temperance Life Insurance Association of the city of New York. There was a judgment for plaintiffs, and defendant brings error. Affirmed.

Before Buffington, McPherson, and Woolley, C. J.

George R. Wallace, of Pittsburgh, Pa., for Plaintiff in Error.

Weil & Thorp, of Pittsburgh, Pa. (S. Leo Ruslander and George K. Warn, both of Pittsburgh, Pa., of counsel), for Defendants in Error.

BUFFINGTON, C. J.

In this case the administrators of Max Solomon, citizens of Pennsylvania, brought suit against the American Temperance Life Insurance Association, a corporate citizen of New York

* Decision rendered, June 12, 1916. 233 Fed. Rep. 213.

state, to recover \$5,000 on a policy of insurance issued on the life of Max Solomon. The policy in question was a ten-year endowment one, on which the deceased had paid several annual premiums. On the first trial of the case the plaintiff recovered. On a writ of error this court, in an opinion reported at 209 Fed. 345, 126 C. C. A. 271, reversed and directed a retrial. On such trial the plaintiff again recovered a verdict, and on entry of judgment the insurance company sued out this writ.

The questions here involved concern statements made in the application for the policy sued on concerning the applicant's age, his drink habits, and prior applications for insurance. The contention of the defendant is that under the evidence it was the duty of the court to hold the policy was invalid and give binding instructions for defendant. The several answers made by the deceased, which are quoted below, were contained in the copy of such application attached to the policy sued on. Such policy recites that it was based on the application for membership in this association, "which the insured hereby warrants to be true, and which is made a part of this contract," and that "this policy is accepted upon the terms stated upon the second page of the policy, which are made a part of this contract." Among the terms thus recited were that:—

"This policy shall be null and void if the insured herein uses, sells or is interested in the sale of alcoholic liquors or intoxicating drinks in any form as a beverage, or for misstatement of age, fraud, nonpayment of any payment or payments due to the association under the conditions of this policy."

[1] In its charge the court, *inter alia*, said:—

"The plaintiffs, of course, rely upon a contract of insurance, and have brought suit upon that contract, and therefore affirm the contract in all respects. * * * The application is part of this contract, and the statements in the application the insured warrants to be true. The application contains a number of questions to be answered, and which in the application are answered. * * * Now those three questions are as follows: 6. Place and date of your birth—9th of August, 1856. 18. Have you ever used wine, beer, alcoholic liquors, or any intoxicating drinks as a beverage? If yes, how long since did you discontinue? State explicitly. Yes, whiskey, 1 glass a week. 10. Had any proposal to insure your life ever been postponed or declined? If so, by what company, association, or society, and for what reason? No. 11. Has any proposal or application to insure your life or for membership ever been made to any company, association, society, or agent upon which a policy or certificate of membership has not been received by you in person for the full amount and kind and at rate applied for? No."

Turning, first, to the subject of prior insurance, the court, *inter alia*, charged:—

"With respect to questions 10 and 11, with regard to applica-

tion for other insurance, those questions are partly for the court and partly for the jury. The jury's part is to determine whether or not the answers to those questions were false. You have heard the testimony on both sides of this case. Was there an application to another company made at the time this application, connected with the policy in suit, was made? If there was an application made, and there had been no policy received, then it would be a postponement, or it would be perhaps a rejection, or if there was another application for the insurance made at the time the application for this policy was made, then the answers to that question were false, and as a matter of law the court will say that they are material to the risk."

This instruction is assigned for error, but we think the instruction was justified. The question was, as stated, a mixed one of fact and law. The law question, namely, the materiality and legal effect of the answers to the question, the court assumed and correctly answered, by holding that, if the answers to that question were false, "as a matter of law the court will say they are material to the risk." As to the question of fact, the court properly submitted it to the jury, correctly holding "the jury's part is to determine whether or not the answers to those questions were false." Under the proofs in the case, it would clearly have been error for the court to have taken that question from the jury. The insured was, of course, bound by his answer that he had not applied for other insurance, or been refused it; but whether he had in point of fact made such application, or it had been declined, was for the jury to determine under the proofs.

[2] We shall not quote in detail the testimony bearing on this question, but shall restrict ourselves to saying that proofs in that regard were such that it was the court's duty to submit them to the jury. In doing so attention was carefully called to the fact that Solomon was bound by the application on which the policy in suit was issued, but that with reference to the application produced by the Hartford Company the question was whether it had been made to that company with his approval and authority. This question was fairly submitted in the charge, as follows:—

"So far as this contract is concerned, it is immaterial whether the insured could read or write, or not, or whether he understood what was contained in his application. The plaintiffs affirm the contract, the contract exists, it cannot be changed or modified in this proceeding, and it is, as I say, immaterial whether the insured could read or write at the time this application was made. But it is a material fact in relation to whether or not an application had been made to another company, and the only evidence in the case here, upon which the defendant relies, is that there was an application made to the Hartford Life Insurance Company for the insurance. It is material in relation to that, as to whether the insured of this defendant company could read or write. Was that application to the Hartford the application of the insured in

the case at bar, made by him or by his authority, not perhaps for his benefit, but with his approval, and with his authority? You have heard the testimony upon the part of the defendant. You have the application from the files of the Hartford Life Insurance Company. You have the testimony with respect to the relations of the insured to the person who witnessed the application in the suit at bar, and who apparently witnessed the other Hartford application, and you have some testimony that the man Kann had a number of applications that were signed in his presence by the insured in this case, by his mark. I must leave that question of fact to you, as to whether or not the Hartford application, offered in evidence here by the defendant, was the application of Max Solomon, either by him personally, or at his instance. If it was, then was it in existence at the time this application attached to the policy in suit was made? If it was, then the answers to questions 10 and 11, which I have read to you, are false, and, if they were false, then they were material to the risk, and there should be no recovery in this case."

[3] It remains to consider the court's treatment of the other two questions quoted above, bearing on decedent's age and his drink habits. In that regard the court submitted the falsity and the materiality of both to the jury, as follows:—

"With respect to the question as to age, and with respect to the question as to the use of alcoholic beverages, you are to determine whether or not they were material questions, under the test that I have stated to you. You have heard the evidence on both sides with respect to the age of the insured. Is the statement false? Was it material if it was false? Those are the questions for you to answer and to consider. So, with respect to whether or not his answer to the question as to the use of alcoholic beverages, was that answer false, and, if it was false, was it material? In other words, would the company have refused to give the insurance, if true answers had been made, and they had known the real facts?"

It is now contended the court erred in submitting the materiality of these questions to the jury. Assuming, for present purposes, that it did err in submitting the materiality of these questions to the jury, a matter, however, on which we express no present opinion, a study of the proofs shows that no such substantial wrong was done the defendant thereby as to warrant a reversal of this judgment on that ground, for the character of proof submitted is such that a court would not have been justified in sustaining a verdict adverse to the policy. On the plaintiffs' side the age of the deceased was affirmatively proved by two members of the decedent's family, while the only witness called by the defendant, who stated the deceased had made another statement as to his age some years before, admitted he was so uncertain about it that his testimony in reality amounted to nothing. So, also, on the issue of the deceased having used liquors as a

beverage there was no such evidence as would have supported a verdict, had the jury so found. The evidence of a very occasional taking of a drink on some special occasion was not the use of liquor as a beverage which was contemplated by his application.

Upon a full consideration of the whole case, we are of opinion no reversible error is shown, and the judgment below is therefore affirmed.

SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FIRST DEPARTMENT.

CHELSEA EXCH. BANK ET AL.

vs.

TRAVELERS' INS. CO.*

2. INSURANCE—PROCEEDS—RIGHT OF JUDGMENT CREDITOR TO NET EQUITY IN LAPSED POLICY.

The rule in bankruptcy that the trustee succeeds to the rights of the bankrupt in life insurance policies, including the reserved right to change the beneficiary, does not apply to case of a creditor seeking to subject insured's policy interest to his judgment, in which case plaintiff can only reach the insured's property.

(For other cases, see Insurance, Cent. Dig. §§ 1479, 1482, 1485; Dec. Dig. § 590.)

Appeal from Special Term, New York County.

Action by the Chelsea Exchange Bank and others against the Travelers' Insurance Company. From an order sustaining plaintiff's demurrer to the first separate defense, defendant appeals. Order reversed, and demurrer overruled.

Argued before Clarke, P. J., and McLaughlin, Laughlin, Scott, and Dowling, JJ.

William J. Moran, of New York City, for Appellant.
W. W. Shaw, of New York City, for Respondents.

DOWLING, J.

[1] This is an action in aid of an attachment. The complaint sets forth that in an action brought in the Supreme Court, New York County, by the Chelsea National Bank against Alfred H. Motley, Jr., a warrant of attachment was duly issued on September 16, 1914, in the sum of \$1,101.25, which was duly served

* Decision rendered, July 10, 1916. 160 N. Y. Supp. 225.

on defendant; the property levied upon consisting of an indebtedness of defendant to said Motley in the sum of \$1,281.63, "being the cancellation value of two certain policies issued by the Travelers' Insurance Company upon the life of Alfred H. Motley, Jr., being Nos. 128565 and 164700, respectively, and a demand upon said the Travelers' Insurance Company to the said Alfred H. Motley, Jr." It is further alleged:—

"That in response to said service of warrant of attachment and demand said defendant the Travelers' Insurance Company duly made and delivered to the said sheriff a certificate setting forth that the said defendant then held the sum of about \$1,281.63, being the cancellation or surrender value of two certain life insurance policies upon the life of said Alfred H. Motley, Jr., but claiming, however, that the said property did not belong wholly to the said Alfred H. Motley, Jr. A copy of said certificate, furnished by the said defendant to the said sheriff of the county of New York, is hereto annexed, marked 'Exhibit A' and made a part hereof, as though incorporated herein."

The various steps taken in the action are then recited, culminating in judgment against Motley on December 14, 1914, and the issuance of execution to the sheriff of the county of New York, which still remains in his hands and is as yet unsatisfied. The complaint sets forth the issuance of the two policies of insurance by the defendant on the life of said Motley, copies of which are annexed to and made a part of the complaint. By the first of these the principal was made payable to Lucy B. Motley, the wife of the insured, as beneficiary, or to such other persons as might be designated by the insured, as provided in said policy, and in the event of the prior death of the said beneficiary, or any other designated beneficiary, then the amount of said policy should be paid to the executors, administrators, or assigns of the insured. Motley changed his beneficiary so as to make the policy payable directly to his executors, administrators, or assigns, and thereafter again changed it so as to make it payable to Lucy B. Motley, the wife of the insured, with the proviso, however, that if the death of the said beneficiary should occur prior to that of the insured, then such insurance should go to the executors, administrators, or assigns of the insured. In and by such designation the right was also reserved to revoke said designation, and, subject to the consent of the company, to nominate a new beneficiary. It is then alleged:—

"That in and by said policy second above mentioned, marked 'Exhibit C,' dated March 1, 1906, it was provided that the principal thereof should be paid to the executors, administrators, or assigns of the insured. That thereafter and on or about the 4th day of March, 1908, the beneficiary named in said policy was thereafter changed by the insured with the consent of the defendant herein, whereby said policy was made payable directly to Lucy B. Motley, the wife of the insured, with the proviso that,

if the said beneficiary should die before the insured, then the policy should be paid to the executors, administrators, or assigns of the insured. That in and by said designation the right was also reserved to the insured to revoke said designation, and, subject to the consent of the company, to nominate a new beneficiary.

"(17) That in the month of July, 1913, both of said policies above mentioned lapsed because of the failure on the part of the insured to pay the premiums due thereon, and that thereafter, and on or about the 28th day of July, 1914, said policies were both duly canceled by the said the Travelers' Insurance Company, at which time there remained a net equity of \$744 on the policy No. 128565 first above mentioned and a net equity of \$537.63 on the policy No. 164700 second above mentioned.

"(18) That the sum of \$1,281.63, being the cancellation or surrender value of said policies above mentioned, remains in the hands of the defendant and is now held by it.

"(19) That by reason of the cancellation of said policies of life insurance upon the life of Alfred H. Motley, Jr., as aforesaid, the said defendant, the Travelers' Insurance Company, on or about the 28th day of July, 1914, became indebted to the said Alfred H. Motley, Jr., in the sum of \$1,281.63, and was so indebted to the said Alfred H. Motley, Jr., on the 16th day of September, 1915, at the time of the service upon it of the attachment in the action of Chelsea Exchange Bank against Alfred H. Motley, Jr."

The certificate of defendant, given on the service of the attachment annexed to the complaint as Exhibit A, shows that both the policies in question lapsed for failure to pay the premiums thereon and were canceled on July 28, 1914, "at which time there remained a net equity of \$744 under No. 128565 and a net equity of \$537.63 under No. 164700; that there is nothing due by this company solely to the said Alfred H. Motley, Jr."

[2] The copies of the policies attached to the complaint as Exhibits B and C contained provisions, in case of default in payment of premiums after the second year, for the automatic extension of insurance for certain terms, and for paid-up policies upon surrender of the original policies. They also contained tables showing, for the end of each year of the policies' life, the term of such automatic extension, the amount of paid-up insurance obtainable, the cash surrender value, and the loan value. The complaint is entirely silent upon the manner in which the so-called "net equity" in the policies was arrived at, nor is any provision of the policies quoted under which that, or any other sum, became payable to the insured upon the lapse of the policies, or by which the interest of the beneficiary therein ceased or became extinguished. There are no allegations in the complaint from which it can be found that defendant is under a present legal duty to pay any one any sum whatever. It does not appear

from the complaint in whose possession the policies are, or that they can be surrendered to the defendant. For aught that appears in the complaint the beneficiary, Lucy B. Motley, still has an interest in the policies and is a necessary party to any determination of the rights of the parties in and under them. The cases cited by plaintiffs arising in bankruptcy cases have no application here, for in the former the trustee in bankruptcy succeeded to all the rights of the bankrupt, including the reserved right to change the beneficiary, which is not the case here, where plaintiffs can only reach the insured's property, and the wife is still the designated beneficiary.

[3-5] The defendant, for a first, separate, and complete defense, repeating all the denials of its main defense, set up:—

"That there is a defect of parties herein, in that neither the assured nor the beneficiary under the policies referred to in the complaint herein has been made a party to this action."

To this separate defense the plaintiff demurred as insufficient. As the defect in parties plaintiff appeared upon the face of the complaint, the defendant's proper remedy was by demurrer. Code Civ. Proc. § 488, subd. 6. It is only where that defect does not appear on the face of the complaint that the objection may be taken by answer. Id. § 498. The objection is waived only when it is taken neither by demurrer nor answer. Id. § 499. But the plaintiffs are in no position to raise the question by demurrer to the separate answer, as the latter incorporates denials which make it proof against demurrer, and the plaintiffs cannot demur to only a part thereof. Wiener vs. Boehm, 126 App. Div. 703, 111 N. Y. Supp. 126. Furthermore:—

"The rule is that on demurrer to an answer for insufficiency the defendant may attack the complaint on the ground that it does not state facts sufficient to constitute a cause of action. * * * A demurrer searches the record for the first fault in pleading, and reaches back to condemn the first pleading that is defective in substance, because he who does not so plead as to invite an issue cannot compel his adversary to so plead as to accept it." Baxter vs. McDonnell, 154 N. Y. 436, 48 N. E. 817; John H. Parker Co. vs. City of New York, 110 App. Div. 360, 97 N. Y. Supp. 200.

As the separate defense incorporated denials which made it good against demurrer, and as the complaint herein does not set forth a good cause of action against defendant, the order appealed from will be reversed, with \$10 costs and disbursements, and the demurrer to the separate defense overruled, with \$10 costs. Order filed. All concur.

SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FIRST DEPARTMENT.

ROSE

vs.

BRISTOL.*

2. INSURANCE — AGENTS — EMPLOYMENT — ACTION FOR BREACH—ISSUES—DENIAL OF IMMATERIAL MATTERS.

In an action for breach of contract of employment as insurance agent, allegations that plaintiff complied with all the rules and regulations of the insurance company and the laws of the state of New York prior to the revocation of his license are not put in issue by a denial, where there is no claim that plaintiff was discharged for any violation of such rules or laws.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

3. INSURANCE—AGENTS—EMPLOYMENT CONTRACT—ACTION FOR BREACH—ISSUES.

In an action for breach of a contract of employment as insurance agent, the allegations of the reply denying that the contract was entered into subject to the Insurance Law of the state, raised no issue, since it must be assumed that the parties contracted with reference to the Insurance Law as it stood at the time the contract was made.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

5. INSURANCE—AGENTS—EMPLOYMENT—BREACH—CANCELLATION OF PLAINTIFF'S LICENSE.

That defendant maliciously caused plaintiff's agency license to be canceled, thus making performance of the contract impossible, did not constitute a breach of the contract.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

6. INSURANCE—AGENTS—BREACH OF CONTRACT—IMPOSSIBILITY OF PERFORMANCE BY ALL DEFENDANTS.

Where an insurance agent's license was canceled by the state insurance commissioner and performance of an agency contract was thus rendered impossible, such agent could not maintain an action for breach of contract; performance thereof being forbidden by Penal Law (Consol. Laws, c. 40) § 1192, after revocation of plaintiff's license.

(For other cases, see Insurance, Cent. Dig. § 115; Dec. Dig. § 85.)

Appeal from Special Term, New York County.

Action by Bernard R. Rose against John I. Bristol. From an order denying a motion for judgment on the pleadings, defendant appeals. Reversed, and motion granted.

Argued before Clark, P. J., and Laughlin, Dowling, Page, and Davis, JJ.

James C. Foley, of New York City, for Appellant.
Harold H. Bowman, of New York City, for Respondent.

* Decision rendered, July 10, 1916. 160 N. Y. Supp. 335.

DAVIS, J.

The court at Special Term denied defendant's motion for judgment on the pleadings. The pleadings consist of a complaint, answer, and reply. The action is brought to recover \$200,000 damages for a breach of contract of employment.

On or about January 11, 1907, the plaintiff, then being duly licensed by the Superintendent of Insurance of the state of New York to solicit insurance as an agent of the Northwestern Mutual Life Insurance Company, entered into a written agreement with the defendant, as general agent of the insurance company, whereby defendant employed the plaintiff to work for him as subagent for a term beginning January 11, 1907, and ending December 31, 1916, and agreed to pay him for the services rendered certain commissions and renewal commissions. The plaintiff continued to work for defendant until about the 7th day of July, 1914. On or about this latter date the plaintiff's license was revoked by the Superintendent of Insurance, after which, it is conceded, the plaintiff could not lawfully solicit business as an agent, or otherwise carry out the terms of the agreement with defendant, nor could the defendant lawfully receive applications from the plaintiff, or otherwise carry out his part of the contract. On January 11, 1907, the date of the contract, the Insurance Law of this state forbade the plaintiff to solicit or accept applications for insurance without first procuring from the Superintendent of Insurance a certificate of authority or license, and by subsequent amendments life insurance companies and their agents were forbidden to pay any form of compensation to any person for services in obtaining new insurance, unless such person shall have first procured a certificate of authority from the Superintendent of Insurance. Thus both plaintiff and defendant concede that the law of the state has made the contract impossible of fulfillment.

The plaintiff, however, contends that, although the law has made it impossible to carry out the terms of the contract, nevertheless the defendant is liable on his absolute undertaking that the plaintiff should remain defendant's agent during the term of the contract, unless his agency was terminated by the company for one of the causes mentioned in the contract. The revocation of plaintiff's license is not one of those specified causes. On the other hand, the defendant claims that the contract was entered into with reference to the existing law of the state, and the law having forbidden the plaintiff to solicit insurance without a license, and likewise the defendant to accept applications from or to pay commissions to a person not licensed as an agent, and having made it a criminal offense under Penal Law, § 1192, for either party to carry out the contract, he was not liable as for a breach thereof.

The complaint contains thirteen paragraphs. The defendant admits the allegations contained in the first, second, fourth, fifth,

sixth and seventh. He also admits all of the allegations of paragraph third, except the allegation that plaintiff's license continued in force until revoked at the instance of the insurance company on or about July 6, 1914. This allegation is denied in the answer; but this denial raises no issue, because the law requires the license to be issued yearly, and, indeed, the plaintiff so alleges in the fourth paragraph of his reply.

[1] The defendant also admits all of the allegations of paragraph eighth of the complaint, except the allegation that he repudiated the contract. This latter allegation is merely a conclusion, and its denial raises no issue to be tried. In fact, it appears from the reply that the "repudiation" referred to was the refusal of the defendant to accept applications from the plaintiff because of the revocation of plaintiff's license by the Superintendent of Insurance.

[2] The defendant also admits all of the allegations of the ninth paragraph of the complaint, except the allegations that plaintiff complied with all of the rules and regulations of the company and the laws of the state down to July 7, 1914 (the date of the revocation of his license), and that plaintiff's income from his business was an increasing income. These latter allegations are denied; but this denial raises no issue, as there is no claim that plaintiff was discharged for any violation of the rules of the company or of the laws of the state. If the truth of these allegations had been admitted or proved, in the view we take of the reason why defendant refused to go on with the contract, it would not help the plaintiff, as these allegations are wholly immaterial.

And the same may be said of the denials of paragraphs tenth and eleventh. In these paragraphs the plaintiff alleges that the contract was entered into subject to and governed by a well-known and invariably recognized custom by virtue of which agents who had served acceptably were entitled to a renewal of their contracts at their expiration, so that plaintiff would be entitled to a renewal of his contract at its expiration. These allegations are immaterial, and the denial of them creates no issue, unless the defendant is held to be liable under the terms of his contract, notwithstanding both parties were forbidden by law to perform it.

Defendant also denies the allegations of the twelfth paragraph. This paragraph is as follows:—

"Twelfth. That on or about the 7th day of July, 1914, while said agreement, 'Exhibit A,' as modified, was in full force and effect, defendant broke his said contract with plaintiff, and, without right or cause, discharged plaintiff from his said employment, and thereafter refused to accept any further applications for insurance in said the Northwestern Mutual Life Insurance Company from plaintiff, or to be in any respect bound by any of the terms of his said agreement with plaintiff, 'Exhibit A,' as so modified, by defendant to be kept and performed. That by rea-

son thereof plaintiff has been deprived of the benefit of his said contract with defendant, as modified, and of the right to the renewal thereof, and of the means of earning his living thereunder, to his damage in the sum of two hundred thousand dollars (\$200,000)."

The sense in which the word "discharged" is used in this allegation is shown by the seventh paragraph of the reply, where the plaintiff states that the cause of his ceasing to be a subagent of the defendant was the revocation of his license, maliciously brought about by the insurance company. This denial, therefore, raises no issue to be tried.

If we examine now the affirmative defense and the reply, a similar absence of material issues will appear. This defense is contained within paragraphs IX and X of the answer, and is substantially as follows: That the contract in question was entered into by the plaintiff and the defendant, subject to and limited as to its continuance by the provisions of the Insurance Law of the State of New York (Consol. Laws, c. 28), which provided, among other things, that no person should solicit or obtain applications for life insurance in any life insurance company unless he was at the time of such solicitation and of obtaining such applications a duly licensed agent of such company under a license issued by the Superintendent of Insurance of the state of New York; and the said law further prohibited all life insurance companies and all agents of such companies from receiving applications for life insurance and from paying any commissions or other compensation for such applications to persons who were not at the time duly licensed agents of the company for and in behalf of which such applications had been obtained. That on the 7th day of July, 1914, the plaintiff was not a duly licensed agent of the Northwestern Mutual Life Insurance Company, and did not on said date or at any time thereafter hold a license from the Superintendent of Insurance of the State of New York authorizing him as agent to solicit applications for life insurance in said company, and that he could not, on and after the said 7th day of July, 1914, lawfully solicit or obtain applications for life insurance in the said company, and that the defendant could not upon the said 7th day of July, 1914, nor at any time thereafter, lawfully receive from the plaintiff any such applications for life insurance in the said life insurance company. That on the said 7th day of July, 1914, and at all times thereafter, the plaintiff herein was prohibited by section 1192 of the Penal Law of the state of New York from soliciting or procuring applications for life insurance in the said the Northwestern Mutual Life Insurance Company, unless he held a license, and that by reason of the force and effect of the said statutes, and by reason of the cancellation of the plaintiff's license, which was effected without any act or procurement and without prior knowledge or privity of this de-

fendant, the contract had been made impossible of performance without any act or fault of this defendant.

[3, 4] The first paragraph of the reply simply denies the allegation in paragraph IV of the answer that the contract was entered into subject to the Insurance Law of the state, and the second paragraph makes denial of the same allegation contained in paragraph X of the answer. These denials raise no issue to be tried. It must be assumed here that the parties contracted with reference to the Insurance Law as it stood at the time the contract was made. *Labaree vs. Crossman*, 100 App. Div. 499, 503, 92 N. Y. Supp. 565, affirmed without opinion 184 N. Y. 586, 77 N. E. 1189. As was said by Justice Page in the case of *Ward vs. Union Trust Co.*, recently decided by this court and reported in 159 N. Y. Supp. 54, 56:—

"When parties enter into a contract, they are presumed to have in mind all the existing laws relating thereto or to the subject-matter thereof. Those laws enter into the contract and define and determine it."

In paragraph III of the reply the plaintiff also denies the last paragraph of X of the answer, which is as follows:—

"That by reason of the force and effect of the said statutes, and by reason of the cancellation of the plaintiff's license, which was effected without any act or procurement or without prior knowledge or privity of this defendant, the said contract, Exhibit A, has been made impossible of performance without any act or fault of this defendant."

[5] Nevertheless the reply sets up the very statute which made performance of the contract impossible, and it nowhere alleges that the cancellation of plaintiff's license was procured by the defendant or through his instrumentality. On the contrary, responsibility for the revocation of the license is placed by the plaintiff upon the insurance company itself. For instance, in paragraph seventh of the reply we find the allegation that the insurance company maliciously caused plaintiff's license to be revoked, and thus made it impossible for plaintiff and defendant alike to carry out the contract. And furthermore, in view of this latter allegation, it is quite apparent that defendant's denial of the allegation of the complaint that defendant unlawfully broke his contract and discharged the plaintiff is not a denial which raises any issue of fact, for upon these pleadings it clearly appears, not that the contract was broken and the plaintiff discharged by defendant, but that the law forbade its performance. Moreover, even if the defendant had improperly caused the cancellation of plaintiff's license, it is doubtful if that act would have constituted a breach of the contract. Such conduct on defendant's part might render him liable for damages in some other cause of action, but not in the one at bar.

The reply further alleges that the insurance company maliciously caused plaintiff's license to be canceled, and thus made

the contract impossible of performance by both parties, because of plaintiff's well-known criticism of the company's methods, and with a desire of the company to be revenged upon plaintiff, and that defendant fully co-operated with plaintiff in making these criticisms, and that, had it not been for the aid thus given by defendant, plaintiff's inability to perform the contract would not have arisen. Assuming the truth of these allegations, it is quite obvious that they constitute no breach of the contract in question.

The reply also sets forth the Insurance Law of the state requiring the possession of a license as a prerequisite of doing business as agent, defendant's knowledge of this law at the time of the execution of the contract, the fact that the contract specified the conditions under which the contract could be canceled, the fact that the contract contained no provision releasing the defendant from the obligation to perform in case plaintiff's license should be revoked at the instance of the company, and the fact that the contract was not terminated for any cause enumerated therein, or for any misconduct of the plaintiff, but because of the malicious act of the insurance company.

[6] Under these allegations it is sought to hold the defendant upon the theory that he warranted and agreed that the company would retain plaintiff as its agent for ten years, except under the conditions specified in the contract, although the act of the company in causing the cancellation of plaintiff's license was in no way attributable to the plaintiff. This contention, we believe, is unsound in law under the circumstances of this case. There is no provision in the contract indicating in the least degree that the defendant undertook, expressly or impliedly, either to procure a license for the plaintiff, or to secure its continuation or renewal, or to secure the continued approval of the plaintiff's agency by the company. It is true, also, that the contract contains no provision that it was to terminate when performance was rendered impossible by the revocation of plaintiff's license under the law. But such a provision is not necessary to relieve the defendant, where, as here, the contract is executory and for personal services. As was said in the case of *Labaree vs. Crossman*, *supra*:

"Stipulations in the contract against such contingencies are not essential to the relief of the party when performance is rendered impossible."

These pleadings show that the case at bar is one in which performance became impossible to both parties under the law, and not through any act or default of the defendant. It is like the case of *People vs. Globe Mutual Life Ins. Co.*, 91 N. Y. 175, where the appointment of a receiver made the agent's contract impossible of performance, and where the court says at page 179:

"The state, by the injunction order operating alike upon the company and its agents, paralyzed the action of both the contracting parties, so that neither could perform [by putting] the other

in the wrong. Thereupon the company could not refuse, and did not refuse. To put it in the wrong, and make it liable for a breach, required action on the part of Mix. As a condition precedent he was bound to show both ability and readiness to perform on his part. *Shaw vs. Republic Life Ins. Co.*, 69 N. Y. 292; *James vs. Burchell*, 82 N. Y. 113. He could do neither. Performance by him had become illegal. It would have been a criminal contempt, and possibly a misdemeanor. There could be neither readiness nor ability to do the forbidden and unlawful acts."

And further on the court say:—

"What had happened was a dissolution of the contract by the sovereign power of the state, rendering performance on either side impossible. And this result was within the contemplation of the parties, and must be deemed an unexpressed condition of their agreement."

From this consideration of the pleadings in this case we have reached the conclusion that they present no issues of fact, the determination of which in favor of the plaintiff would entitle him to a judgment against the defendant.

The order denying defendant's motion for judgment on the pleadings is reversed, with \$10 costs and disbursements, and the motion granted, with \$10 costs. Order filed. All concur.



CLINTON *vs.* MODERN WOODMEN OF AMERICA.

(No. 117.)*

(Supreme Court of Arkansas.)

INSURANCE—FRATERNAL INSURANCE—DELIVERY OF CERTIFICATE—NECESSITY.

Where the by-laws of a fraternal benefit society contained the provision that a member's certificate should not be effective until delivery to insured while in sound health, etc., and there was no delivery of the certificate by the clerk of the applicant's lodge, and no attempt made to ascertain the applicant's health, who had been taken ill with appendicitis immediately upon receipt of the certificate by the clerk from the home office, and died the next day, the society was not liable for the death benefit.

(For other cases, see Insurance, Cent. Dig. § 1856; Dec. Dig. § 720.)

Appeal from Circuit Court, Yell County; Marcellus L. Davis, Judge. Suit by Mrs. Maud G. Clinton against the Modern Woodmen of America. From a judgment for defendant, plaintiff appeals. Judgment affirmed.

* Decision rendered, July 3, 1916. 187 S. W. Rep. 939.

Jno. B. Crownover, of Dardanelle, for Appellant.
Truman Plantz, of Warsaw, Ill., George G. Perrin, of Rock Island, Ill., and Jas. A. Gray, of Little Rock, for Appellee.



DUNN vs. COLUMBIAN NAT. LIFE INS. CO. (No. 7109.)*

(Court of Appeals of Georgia.)

1. INSURANCE — ACTIONS ON POLICIES — EVIDENCE — ADMISSIBILITY.

The secretary of the insurance company testified: "It is the universal rule to send to the insured, when a policy has been canceled on the books, a notice of lapse, on a blank form. No record is kept of sending such notices, because it is the universal custom of my office to do so. I have no doubt but that a lapse notice was sent to George E. Wallace at the same time, May 20, 1913." On objection to this testimony on the ground that "it was not competent to show what was the rule or custom" in sending out such notices, and that the defendant "could only show that such notice had been actually sent to the insured," the trial judge ruled out "the expression as to the practice," and allowed the other part of the testimony to remain in, "subject to be connected up." This was not error; another witness testifying that the insured said to him, "I have received a notice of cancellation from the office." This also made the blank lapse notice admissible.

(For other cases, see Insurance, Cent. Dig. §§ 1674, 1686; Dec. Dig. § 654½.)

3. INSURANCE—FORFEITURE—DEFAULT—PREMIUM NOTE.

The policy sued on provided that it should be "incontestable after one year from its date of issue, except for nonpayment of premium," etc. A premium fell due and was unpaid, and certain notes for this premium were given by the insured, each providing that it was "given with the full knowledge and intent * * * that, if it is not paid when due, without grace, said policy shall, without further notice, become void, and the insurance thereby terminate as of the date to which premiums have been paid in cash, subject to the conditions therein relating to surrender value." One of these notes was not paid, and the company unequivocally canceled the policy, giving the insured notice of the cancellation, in which he acquiesced, saying that he knew he had to do something like being re-examined before reinstatement. The company retained the notes, but made no effort to collect. The policy provided that no modification of the insurance contract should be made, except over the signature of the president or the secretary, and no such modification was shown. The court did not err in directing a verdict for the company. *Shapre vs. New York Life Ins. Co.*, 5 Neb. (Unof.) 278, 98 N. W. 66; *Klein vs. New York Life Ins. Co.*, 104 U. S. 88, 26 L. Ed. 662; *Iowa Life Ins. Co. vs. Lewis*, 187 U. S. 335, 23 Sup. Ct. 126, 47 L. Ed. 204; *Bank of Commerce vs. New York Life Ins. Co.*, 125 Ga. 554, 54 S. E. 643; *Hipp vs. Fidelity Insurance Co.*, 128 Ga. 497, 57 S. E. 892, 12 L. R. A. (N. S.) 319. These authorities bear precisely upon the question now decided,

* Decision rendered, July 6, 1916. 89 S. E. Rep. 432. Syllabus by the Court.

and in the light thereof, and since the decisions of the Supreme Court of this state are binding as precedents upon this court, the ruling in the case of Arnold vs. Empire, etc., Insurance Co., 3 Ga. App. 685, 60 S. E. 470, so far as it conflicts with the principle laid down in Bank of Commerce vs. New York Life Ins. Co., and Hipp vs. Fidelity Ins. Co., *supra*, will not be followed.

(For other cases, see Insurance, Cent. Dig. §§ 897, 898; Dec. Dig. § 349[3.]

Error from City Court of Atlanta; H. M. Reid, Judge.

Action by L. J. Dunn, administrator, against the Columbian National Life Insurance Company. Judgment for defendant, and plaintiff brings error. Affirmed.

Walter R. Daley and Hines & Jordan, all of Atlanta, for Plaintiff in Error.

Colquitt & Conyers, of Atlanta, for Defendant in Error.



METROPOLITAN LIFE INS. CO. vs. DAY. (No. 411.)*

(Supreme Court of Georgia.)

DAMAGES—INSURANCE—LIABILITY OF INSURER—EXTENT.

By the terms of an insurance policy the insurer promises to pay the beneficiary "the sum of \$136 on receipt at said home office of due proof of the death of the insured, and fifty-nine further payments, monthly thereafter, of \$25 each, until \$1,611 in all shall have thus been paid." The policy further stipulated: "The commuted value of the installment payments, as above provided, is \$1,500. If there be no designated beneficiary, original or substitute, when this policy becomes a claim by the death of the insured, such commuted value, less any indebtedness to the company hereunder, will be paid in one sum to the executors, administrators, or assigns of the insured. * * * Upon the death of the insured, the beneficiary of record at the time of such death shall surrender this policy to the company in exchange for a supplementary contract providing for the installments payable in accordance with the conditions of this policy. Such supplemental contract shall provide that the company be furnished with satisfactory evidence that the beneficiary is living at the time each installment is payable thereunder, and that, if not living, the company shall be furnished with satisfactory evidence of a claimant's authority to receive the commuted value of any installments remaining unpaid. * * * If the designated beneficiary shall die before receiving all the installments payable, the remaining payments shall be commuted at the rate of $3\frac{1}{2}$ per centum compound interest, and paid in one sum to the executors or administrators of the beneficiary under the supplementary agreement." Upon the death of the insured the beneficiary furnished proofs of death, and delivered the policy to the company, and demanded the execution and delivery of the supplementary agreement as provided in the policy. The company denied liability and refused to execute the supplementary agreement, claiming

* Decision rendered, May 13, 1916. 89 S. E. Rep. 576. Syllabus by the Court.

that the policy was forfeited by its terms, because the insured died by his own hands within a year after the policy was written. In a suit on the policy, praying damages for breach of covenant to execute and deliver the supplementary contract, under the foregoing facts, where it did not appear that the insured died by his own hand, the beneficiary was entitled to recover, and the measure of damages is the value of the installment payments as provided in the policy, reduced to their present value at the time the insured repudiated liability and refused to execute the supplementary contract, computed at 7 per centum per annum, and interest on the present worth as thus ascertained at the rate of 7 per centum per annum from that time.

(For other cases, see Damages, Cent. Dig. §§ 339-343; Dec. Dig. § 125; Insurance, Cent. Dig. § 1663; Dec. Dig. § 646[7].)

Error from Superior Court, Bartow County; A. W. Fite, Judge.

Action by Ila Day against the Metropolitan Life Insurance Company. Judgment for plaintiff, and defendant brings error. Affirmed, with direction.

The action was by Mrs. Ila Day against the Metropolitan Life Insurance Company. The petition alleged that she was the widow of the insured, and the beneficiary under the policy of insurance, and that in consideration of the sum of \$36.75 the defendant executed and delivered to her husband, Walter G. Day, its policy of insurance on his life. It was a twenty-year payment policy. It provided that the insurance company—"promises to pay, at the home office of the company in the city of New York, * * * to Ila Day, wife of the insured, herein called the beneficiary, the sum of \$136, on receipt at said home office of due proof of the death of the insured, and fifty-nine further payments monthly thereafter, of \$25 each, until \$1,611 in all shall have thus been paid. * * * The commuted value of the installment payments, as above provided, is \$1,500. If there be no designated beneficiary, original or substitute, when this policy becomes a claim by the death of the insured, such commuted value, less any indebtedness to the company hereunder, will be paid in one sum to the executors, administrators, or assigns of the insured. * * * Upon the death of the insured, the beneficiary of record at the time of such death shall surrender this policy to the company in exchange for a supplementary contract providing for the installments payable in accordance with the conditions of this policy. Such supplemental contract shall provide that the company be furnished with satisfactory evidence that the beneficiary is living at the time each installment is payable thereunder, and that, if not living, the company shall be furnished with satisfactory evidence of a claimant's authority to receive the commuted value of any installments remaining unpaid. * * * If such right is given to the beneficiary by the insured, any installment payments yet to be made may at any time be commuted at the rate of 3½ per centum per annum compound interest, and be paid in one sum, but no beneficiary may assign or commute installment payments unless such right has been given by the insured, and is endorsed on the policy by the company at its home office during the lifetime of the insured. If the designated beneficiary shall die before receiving all the installments payable, the remaining payments shall be commuted at the rate of 3½ per centum per annum compound interest, and be paid in one sum to the executors or administrators of the beneficiary under the supplementary agreement."

It was further alleged that the insured was dead, and at the time of his death all accrued premiums due upon the policy had been paid. The petitioner furnished to the defendant, in accordance with the terms of the policy, due proofs of the death of the insured. In accordance with the terms of the policy for the modes of settlement, the petitioner delivered

the same to the defendant, to be exchanged for a supplementary contract providing for installments payable in accordance with the conditions of the policy. The defendant refused to execute and deliver the supplementary contract, and repudiated all liability thereunder, except for the return of the premium of \$36.75, which amount was tendered to her. She refused to accept such tender, and returned same to the defendant, with the demand that the defendant comply with the terms of the policy of insurance. In reply to this demand the defendant, through its duly authorized superintendent, returned the policy, and in a letter stated that: "The company does not intend to make any further settlement than that proposed, which is in accord with the terms of the policy."

It was alleged that the defendant was indebted to petitioner, under the terms of the policy, in the sum of \$1,500, besides interest, "which is the commuted value of said policy of insurance, and which said commuted value petitioner hereby elects to take." The prayer was for judgment for her said debt, and, by amendment, for such other legal or equitable relief as she may be entitled to, under the facts stated, and by reason of the defendant's breach of its contract. The defendant admitted that all premiums had been paid, and that it had received certain papers purporting to be proofs of the death of the insured, but denied that such proofs showed the death of the insured in the manner authorizing any recovery to be had on account of his death under the policy. It admitted that the plaintiff had delivered to it the policy and requested that the defendant exchange for it a supplementary contract as provided in the policy, and that it repudiated all liability under this contract. It tendered to the plaintiff the premium of \$36.75, and the same was returned to it. It further pleaded that the policy contained a provision that it would be released from all liability thereunder if the insured, within one year from the issuance thereof, should die by his own hand or act, whether sane or insane, and in such event the company should not be liable for a sum greater than the premium which had been received on the policy; that the insured within one year from the issuance of the policy died by his own hand or act; and that the defendant, in accordance with the terms of the policy, tendered to the beneficiary \$36.75, which was the full premium received on the policy, and this tender was refused by her. On the trial the plaintiff testified that she was the widow of the insured, that he died on December 3, 1913, and the last time she saw him alive was on the 1st day of December, 1913. The full policy was also introduced in evidence. The court directed a verdict:—

"That plaintiff recover of the defendant the cash value of the installments provided for in the policy of insurance, as of June 2, 1914, with interest from said date at 7 per cent per annum."

A motion for a new trial was overruled, and the defendant sued out a writ of error.

Smith, Hammond & Smith, of Atlanta, and Neel & Neel, of Cartersville, for Plaintiff in Error.

Colquitt & Conyers, of Atlanta, and William T. Townsend, of Cartersville, for Defendant in Error.

SIMS *vs.* JEFFERSON STANDARD LIFE INS. CO.
(No. 6968.)*

(Court of Appeals of Georgia.)

INSURANCE—NONPAYMENT OF PREMIUM NOTE—FORFEITURE OF POLICY.

Ordinarily the failure of the insured to pay at maturity a promissory note given by him, and accepted by the insurer, for a premium on his policy of life insurance, will not ipso facto cause a forfeiture of the policy, although there is a stipulation in the note that if it is not paid at maturity the policy will be forfeited, where there is no provision in the policy itself that it will be avoided for the nonpayment of any note given for premium. In such a case, when the policy lapses on account of the nonpayment of the note, before the policy can be avoided the unpaid note must be returned to the insured. The insurer cannot keep the note and avoid the policy.

- (a) Where, however, the unpaid note contains the express stipulation that "if not paid at maturity it will automatically cease to be a claim against the maker," the policy may be avoided without returning the note.

(For other cases, see Insurance, Cent. Dig. §§ 897, 898; Dec. Dig. § 349[3].)

Error from City Court of Carrollton; Jas. Beall, Judge.

Action by Mary Sims against the Jefferson Standard Life Insurance Company. Judgment for defendant, and plaintiff brings error. Affirmed.

S. Holderness, of Carrollton, for Plaintiff in Error.

Bryan & Middlebrooks, of Atlanta, and Boykin & Boykin, of Carrollton, for Defendant in Error.

* Decision rendered, June 30, 1916. 89 S. E. Rep. 445. Syllabus by the Court.



O'CONNOR *vs.* KNIGHTS AND LADIES OF SECURITY.
(No. 30763.)*

(Supreme Court of Iowa.)

1. INSURANCE—WAIVER EFFECTING TO AVOID POLICY—IMPLIED WAIVER.

In an action on a policy of benefit insurance, where the association's constitution and by-laws provided that premiums and assessments are due on the first day of each month, and that if not paid before the last day of the month the policyholder is automatically suspended without notice, and that one suspended is not entitled to reinstatement unless in good health, where the plaintiff's check, dated February 16th, at which time he was in good health, was not received by the defendant

* Decision rendered, June 29, 1916. 158 N. W. Rep. 761.

until March 5th, at which time he was dangerously ill, no inquiry being made touching the health of the insured and no notice being given the insured that the check arrived too late, and the company knowing or having reason to believe that the check was not sent for the purpose of reinstatement, but to comply with the contract, there being no evidence of fraud on the part of the insured, by accepting the check as far as the February payment and sending him a receipt therefor and by subsequently receiving payments in months following, defendant elected to waive the provisions of the policy and plaintiff had the right to assume that the contract still existed; it being a waiver of "failure to pay within time."

(For other cases, see Insurance, Cent. Dig. §§ 1909-1913, 1915, 1916; Dec. Dig. 755[3].)

2. INSURANCE—FORFEITURE OF POLICY—REINSTATEMENT.

Where a policy of benefit insurance provided for forfeiture of the contract in case of default in payment of monthly premiums, upon being suspended, in order to be reinstated upon terms of the policy it would be incumbent upon the assured to make a showing as to his health, and any fraud practiced touching this matter or concealment on his part of a fact that would prevent reinstatement would be fatal to his right.

(For other cases, see Insurance, Cent. Dig. § 1924; Dec. Dig. § 761.)

4. INSURANCE—BY-LAWS AND CONSTITUTION—AGENTS.

Though the by-laws and constitution of a benefit association provided that the officers of the local councils were the agents of the insured, and that their acts were not binding upon the association, as such provisions are made a part of the contract of insurance, the local council and its officers are the agents of the national association in receiving applications for membership, and collecting fees, charges and assessments, since a person's character must be determined from what he is, and not what he is called.

(For other cases, see Insurance, Cent. Dig. § 1838; Dec. Dig. § 697.)

5. INSURANCE—FORFEITURE OF POLICY—WAIVER.

Although, where, by the terms of the policy of insurance, a member's delinquency ipso facto works a suspension and forfeiture of rights under the policy, no affirmative action is required by the company, and immediately upon the delinquency happening the membership is terminated; the provision, being made for the benefit of the insurer, may be waived by an intention on the part of the company not to insist upon an enforcement of that provision of the contract, and a waiver of the right to insist upon payment within the stipulated time holds the original contract in force and is not the making of a new contract.

(For other cases, see Insurance, Cent. Dig. § 1907; Dec. Dig. § 755[1].)

Appeal from District Court, Chickasaw County; W. J. Springer, Judge.
Action to recover amount alleged to be due on a benefit certificate issued on the life of plaintiff's husband. Judgment for the plaintiff in the court below. Defendant appeals. Affirmed.

M. E. Geiser, of New Hampton, for Appellant.
Smith & O'Connor, of New Hampton, for Appellee.

POWER *vs.* MODERN BROTHERHOOD OF AMERICA.
(No. 20020.)*

(Supreme Court of Kansas.)

1. INSURANCE—TRIAL—FRATERNAL BENEFICIARY INSURANCE—ACTIONS—INSTRUCTIONS.

In an action upon a beneficiary certificate containing a clause that the certificate should be void in case of insured's death by "suicide, sane or insane," the undisputed facts showed that deceased shot himself through the head with a pistol, almost immediately after having declared his intention to kill himself, and that his death was the result of the pistol shot. *Held*, an instruction that, if the jury believed from the evidence that the mental faculties of the deceased "were so obscured and deranged that he did not understand that the firing of said shot was likely to or would result in his death," his act was in the nature of an accident, and the plaintiff would be entitled to recover notwithstanding the provisions of the certificate, is erroneous: (a) Because it excludes all consideration of the intention with which the act was committed, and includes within the definition of "accident" an act of self-destruction which if committed by a sane person with intent to take his life would be suicide. (b) Because there was no evidence upon which the instruction could be based.

(For other cases, see Insurance, Cent. Dig. § 2010; Dec. Dig. 826[2]; Trial, Cent. Dig. § 604; Dec. Dig. § 252[14].)

2. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—ACTIONS—EVIDENCE.

It is *held* that the finding of the jury that the pistol was discharged accidentally and unintentionally is contrary to the undisputed facts shown by the evidence.

(For other cases, see Insurance, Cent. Dig. § 2006; Dec. Dig. § 819[4].)

3. INSURANCE—FORFEITURE—SUICIDE, SANE OR INSANE.

In this case it is held that, as the unmistakable extrinsic evidence of deceased's intention to take his own life and the other known facts are inconsistent with the theory of accidental death, or that deceased did not understand the natural result of his acts, the case is controlled by the decision in Hart *vs.* Modern Woodmen, 60 Kan. 678, 57 Pac. 936, 72 Am. St. Rep. 380, and therefore the clause in the certificate limiting liability in case of "suicide, sane or insane," prevents a recovery.

(For other cases, see Insurance, Cent. Dig. § 1956; Dec. Dig. § 788[1].)

Appeal from District Court, Wyandotte County; Frank D. Hutchings, Judge.

Action by Bertha M. Power against the Modern Brotherhood of America. From a judgment for plaintiff, defendant appeals. Reversed.

David F. Carson, of Kansas City, and Sam Sparrow and James R. Page, both of Kansas City, Mo., for Appellant.

J. H. Brady, E. H. Henning, Junius W. Jenkins, and Charles E. Thompson, all of Kansas City, for Appellee.

* Decision rendered, July 8, 1916. On rehearing, July 29, 1916. 158 Pac. Rep. 870. Syllabus by the Court.

KIRKPATRICK vs. ABRAHAMS ET AL.—NATIONAL COUNCIL OF KNIGHTS AND LADIES OF SECURITY vs. FARRELLY. (No. 20816.)*

(Supreme Court of Kansas.)

1. INSURANCE—FRATERNAL BENEFIT SOCIETIES—ORGANIZATION.

Since the act of 1898, providing for the organization and regulation of fraternal beneficiary societies, took effect, constitutions of societies organized before 1898 and continuing to do business under the act without reincorporation are to be treated in the light of articles of association or charters under the act, so far as they relate to the same subjects, including provisions relating to plan of organization and provisions for amendment.

(For other cases, see Insurance, Cent. Dig. § 1833; Dec. Dig. § 693.)

2. INSURANCE—FRATERNAL BENEFIT SOCIETIES—CONSTITUTION—AMENDMENT.

The plan of organization of such a society, set forth in its constitution, cannot be amended by a simple by-law not enacted according to the provision of the constitution relating to its amendment.

(For other cases, see Insurance, Cent. Dig. § 1833; Dec. Dig. § 693.)

3. INSURANCE—FRATERNAL BENEFIT INSURANCE—CONSTITUTION AND BY-LAWS.

Section 56 of the by-laws of the Knights and Ladies of Security, a fraternal beneficiary society of the character described in paragraph 1 above, providing that appointments by the National President to committees the members of which become ex officio members of the supreme legislative body shall not become effective until approved by the National Executive Council, contravenes section 2 of article 4 of the constitution of the order, giving the president unconditional power to make such appointments.

(For other cases, see Insurance, Cent. Dig. § 1833; Dec. Dig. § 693.)

West, J., dissenting.

Original application by W. B. Kirkpatrick, as National President of the Knights and Ladies of Security, for writ of mandamus to John Abrahams and others, and application by the National Council of the Knights and Ladies of Security, for writ of quo warranto to H. P. Farrelly. The applicant in the mandamus proceeding held entitled to writ of mandamus, but necessity therefor obviated by compliance by defendants with demands of plaintiffs, and costs taxed to the National Council, the plaintiff in the quo warranto proceeding.

Edwin D. McKeever, of Topeka, for Plaintiffs.

Blair, Magaw & Lillard and A. M. Harvey, all of Topeka, for Defendants.

* Decision rendered, July 8, 1916. : 159 Pac. Rep. 13. Syllabus by the Court.

**FARRAGHER *vs.* KNIGHTS AND LADIES OF SECURITY.
(No. 20282.)***

(Supreme Court of Kansas.)

**1. INSURANCE—FRATERNAL BENEFIT INSURANCE—ACTIONS
—EVIDENCE.**

In an action to recover upon a beneficiary certificate, the defense was that the insured made false and fraudulent representations in his answers to questions asked by defendant's medical examiner, in which deceased stated that he had not consulted or been treated by any physician or surgeon during the previous five years for any illness, disease, or injury, and had never undergone any surgical operation. Within a year previous he had been circumcised by a physician, who on later occasions dressed the wound, and who testified that, in his opinion, the insured was in perfect health at the time, and that the circumcision was performed for sanitary purposes. There was proof that the death of insured resulted from a disease which had no relation to the circumcision, and physicians and surgeons testified that they did not regard circumcision as an operation. Defendant's medical examiner testified that, if he had been informed of the fact, he might not have considered it serious enough to mention in the application. Upon these facts, and others stated in the opinion, the finding of the trial court that defendant failed to show the intentional suppression of any fact or circumstance which deceased naturally supposed would tend to influence defendant in passing upon his application, and that plaintiff is entitled to recover, will not be disturbed.

(For other cases, see Insurance, Cent. Dig. § 2007; Dec. Dig. § 819[2].)

**2. INSURANCE—FORFEITURE—MISREPRESENTATIONS IN AP-
PLICATION.**

It will not do to place an absolutely literal interpretation on the provisions in an application and policy of life insurance with respect to untruthful answers. There must not be evasion, fraud, or suppression of facts; there must be absolute good faith in the conduct of the applicant; but where the evidence shows there has been no evasion, no purpose to conceal any fact which the applicant would naturally suppose was contemplated by the questions, and where the company issuing the policy could not have been prejudiced by the answers, and the death of the insured resulted from causes wholly unrelated to the matter about which the alleged untruthful answers were given, a defense based upon their untruth cannot avail.

(For other cases, see Insurance, Cent. Dig. § 1859; Dec. Dig. § 723[2].)

Appeal from District Court, Labette County.

Action by Margaret Farragher against the Knights and Ladies of Security. Judgment for plaintiff, and defendant appeals. Affirmed.

W. W. Brown and James W. Reid, both of Parsons, for Appellant.
John Madden and C. E. Cooper, both of Parsons, for Appellee.

* Decision rendered, July 8, 1916. 159 Pac. Rep. 3. Syllabus by the Court.

**MARSHALL vs. FARMERS' & BANKERS' LIFE INS. CO.
(No. 20053.)***

(Supreme Court of Kansas.)

1. INSURANCE—FORFEITURE—NONPAYMENT OF PREMIUM NOTE.

Where a promissory note is taken for a premium on a life insurance policy, and the insurance policy provides that the note is not to be considered as a payment of the premium, but only an extension of time for payment, and that a failure to pay the note at maturity shall forfeit the policy, a default in payment of the note relieves the insurance company from the payment of the policy.

(For other cases, see Insurance, Cent. Dig. §§ 897, 898; Dec. Dig. § 349[3].)

2. INSURANCE—FORFEITURE—NONPAYMENT OF PREMIUM NOTE.

Where a promissory note is taken for a premium on a life insurance policy, payable to the agent of the insurance company and is received by him as agent for the company and delivered by him to the company, the insurance company is the owner of the note from the inception of the transaction, and if the note is not paid to the company at maturity, the forfeiture clause in the policy for nonpayment of the premium note will protect the insurance company.

(For other cases, see Insurance, Cent. Dig. §§ 897, 898; Dec. Dig. 349[3].)

3. INSURANCE—FORFEITURE—NONPAYMENT OF PREMIUM NOTE.

Where a premium note is taken by the agent of an insurance company in his capacity as agent and the note is delivered to the company, and by an arrangement between the agent and the company, he is conditionally charged with the company's share of the premium, the charge to be remitted if the note is not paid, the premium note belongs to the insurance company from the inception of the transaction, notwithstanding that it is payable to the agent; and where the policy issued to the maker of the note provides that the obligation of the policy shall be void, unless the note is paid at maturity, a failure of the assured to pay the premium note avoids the policy.

(For other cases, see Insurance, Cent. Dig. §§ 897, 898; Dec. Dig. § 349[3].)

4. INSURANCE—FORFEITURE—NONPAYMENT OF PREMIUM NOTE.

A life insurance policy was issued to the husband of the plaintiff beneficiary. The policy provided that it should be void if any premium or premium note was not paid when due. The insured gave his note for the first premium, defaulted in its payment, and soon after died. The note was made payable to the agent of the insurance company, but it was admitted that he merely received it in his capacity as agent, and that he delivered it to the company. It was also admitted that for the convenience of the insurance company and its agent, and agreeable to an understanding between them, when a premium note was taken for an insurance policy, the agent should be conditionally charged with the company's share of the premium, and that the charge should be remitted if the note was not paid, but that in such case the

* Decision rendered, July 8, 1916. 159 Pac. Rep. 17. Syllabus by the Court.

agent should pay the medical fee for examining the applicant for the policy. *Held*, that the insurance company was interested in the premium note as owner from the inception of the transaction, and that these admissions show that credit was not independently extended to the applicant by the agent on his own responsibility, and that by the plain terms of the policy the default of the insured to pay the premium note when due relieved the insurance company from liability on the death of the insured.

(For other cases, see Insurance, Cent. Dig. §§ 897, 898; Dec. Dig. § 349[3].)

Appeal from District Court, Sumner County.

Action by Maud L. Marshall against the Farmers' & Bankers' Life Insurance Company. From a judgment for plaintiff, defendant appeals. Reversed, with instructions.

J. A. Brubacher, of Wichita, and James Lawrence, of Wellington, for Appellant.

W. W. Schwinn, of Wellington, for Appellee.

SOWICZKI vs. MODERN WOODMEN OF AMERICA.

(two cases).*

(Supreme Court of Michigan.)

1. INSURANCE — MUTUAL BENEFIT OFFICERS — WAIVER POWER.

Where a policy was issued by the head camp of a fraternal association whose by-laws limited the persons who might become beneficiaries and provided that no clerk of a local camp could waive the provision, the clerk was divested of waiver power.

(For other cases, see Insurance, Cent. Dig. § 1908; Dec. Dig. § (755[2].)

2. INSURANCE — MUTUAL BENEFIT — ACTIONS — QUESTION FOR JURY—HEALTH OF ASSURED.

Evidence as to whether assured was, or believed himself to be, in good health when applying for fraternal benefit assurance, *held* to present a jury question.

(For other cases, see Insurance, Cent. Dig. § 2009; Dec. Dig. § 825[2].)

3. INSURANCE — MUTUAL BENEFIT — CONTRACT—MISREPRESENTATIONS—HEALTH AND MEDICAL ATTENDANCE.

An applicant's representations to a fraternal benefit association as to his previous health and treatment by physicians are material to the risk.

(For other cases, see Insurance, Cent. Dig. § 1863; Dec. Dig. § 723[5, 6].)

4. INSURANCE — MUTUAL BENEFIT — ACTIONS — PRESUMPTIONS—MEMBERSHIP APPLICATION.

There is a presumption that a fraternal benefit applicant understandingly answered and signed the application.

(For other cases, see Insurance, Cent. Dig. §§ 1999, 2000; Dec. Dig. § 817[1].)

* Decision rendered, July 21, 1916. 158 N. W. Rep. 891.

5. INSURANCE—MUTUAL BENEFIT—QUESTION FOR JURY—AVOIDANCE AND FORFEITURE.

Assured's applying for fraternal insurance through an interpreter does not raise an issue as to whether he understood the application, where he had lived in this country nine years, affirmed his ability to understand English in the application, and the interpreter and examiner testified that it was explained to him.

(For other cases, see Insurance, Cent. Dig. § 2009; Dec. Dig. § 825[2].)

Error to Circuit Court, Wayne County; Orien S. Cross, Judge.

Actions by Ludwica and Anthony Sowiczki against the Modern Woodmen of America. Judgment for defendant, and plaintiffs bring error. Affirmed.

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, Brooke, and Person, JJ.

Clarence P. Milligan, of Detroit, for Appellants.
Beaumont, Smith & Harris, of Detroit, for Appellee.

**BARBER vs. HARTFORD LIFE INS. CO. (No. 17664.)***

(Supreme Court of Missouri, Division No. 1.)

7. INSURANCE—ACTIONS—BURDEN OF PROOF—VALIDITY OF UNPAID ASSESSMENT.

An insurance company, seeking to avoid payment of a policy because forfeited by nonpayment of an assessment, must prove that the assessment was levied in accordance with the contract.

(For other cases, see Insurance, Cent. Dig. § 1653; Dec. Dig. § 646[3].)

8. INSURANCE—FORFEITURE—NONPAYMENT OF ASSESSMENT—EXCESSIVE ASSESSMENT.

Forfeiture of an insurance policy cannot be predicated upon nonpayment of an assessment which was excessive, both under the contract itself and as modified by a foreign judgment.

(For other cases, see Insurance, Cent. Dig. §§ 925-930; Dec. Dig. § 362.)

9. INSURANCE—CONTRACTS—MODIFICATION.

Where the policy provides that annual dues should be paid on a certain date, the insurance company cannot, without the consent of the policyholder, change the date of payment.

(For other cases, see Insurance, Cent. Dig. § 396; Dec. Dig. § 186[2].)

10. INSURANCE—ASSESSMENT—POWER TO LEVY.

Where an insurance company's charter intrusted all its affairs to a board of directors and the making of by-laws to the stockholders, *held*, that

* Decision rendered, March 30, 1916. Rehearing denied and motion to transfer to Court in Banc overruled, July 3, 1916. 187 S. W. Rep. 867.

its executive officers lacked power to levy assessments unauthorized by the directors or the by-laws.

(For other cases, see Insurance, Cent. Dig. § 416; Dec. Dig. § 191.)

11. INSURANCE—ACTIONS—SUFFICIENCY OF EVIDENCE—VEXATIOUS FAILURE TO PAY.

Under Rev. St. 1909, § 7068, a jury may assess punitive damages and an attorney's fee against an insurance company upon concluding, from a general survey, that its refusal to pay the claim was vexatious and no explicit proof to that effect is necessary.

(For other cases, see Insurance, Dec. Dig. § 665[1].)

Appeal from Circuit Court, Johnson County; C. A. Calvird, Judge.

Action by Rosa Barber against the Hartford Life Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Jones, Hocker, Hawes & Angert, of St. Louis, J. W. Suddath & Son, of Warrensburg, and James E. Jones, Jr., of St. Louis, for Appellant.

Nick M. Bradley, of Warrensburg, and Robert Kelley and Charles E. Morrow, both of St. Louis, for Respondent.



BARBER vs. HARTFORD LIFE INS. CO. (No. 17663.)*

(Supreme Court of Missouri, Division No. 1.)

Appeal from Circuit Court, Johnson County; C. A. Calvird, Judge.

Action by Rosa Barber against the Hartford Life Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Jones, Hocker, Hawes & Angert, of St. Louis, J. W. Suddath & Son, of Warrensburg, and James E. Jones, Jr., of St. Louis, for Appellant.

Nick M. Bradley, of Warrensburg, and Robert Kelley and Charles E. Morrow, both of St. Louis, for Respondent.

BROWN, C.

This is a suit on a policy or certificate of insurance for \$1,000 in the safety fund department of defendant, dated February 14, 1890. The defense rested upon the alleged forfeiture of the indemnity by failure to pay the same assessment in issue in the case between the same parties, No. 17,664, and decided by us at this term, 187 S. W. 867. Although there were separate trials, the records are the same in all respects, except that in case No. 17,664 an additional abstract was filed showing the due authentication and offer of the entire record in *Ibs vs. Hartford Life Insurance Co.*, decided by the Superior Court of Connecticut for New Haven County, while in this case the final judgment only was offered and excluded by the trial court. We consider that case as if the judgment had been in evidence, and applying the same rule to this appeal the judgment of the circuit court will have to be affirmed, which is done.

Railey, C., not sitting.

PER CURIAM.

The foregoing opinion of Brown, C., is adopted as the opinion of the court. All concur.

* Decision rendered, March 30, 1916. Rehearing denied and motion to transfer to Banc overruled, July 3, 1916. 187 S. W. Rep. 874.

HOETTE *vs.* NORTH AMERICAN UNION. (No. 14430.)*
(St. Louis Court of Appeals. Missouri.)

1. INSURANCE—LIFE INSURANCE—SUICIDE OF INSURED—EVIDENCE—SUFFICIENCY.

In an action on a life insurance policy, evidence held insufficient to warrant a peremptory instruction for defendant on the ground that decedent committed suicide by drinking carbolic acid.

(For other cases, see Insurance, Cent. Dig. § 2006; Dec. Dig. § 819[4].)

2. INSURANCE—LIFE INSURANCE—SUICIDE OF INSURED—PRESUMPTION AGAINST SUICIDE—BURDEN OF PROOF.

In an action on a life insurance policy, the presumption against the suicide of the insured is very strong, and the burden is on the insurer, who claims that the insured committed suicide by drinking carbolic acid, to show that he not only drank the carbolic acid, but that he took it with suicidal intent.

(For other cases, see Insurance, Cent. Dig. § 1999; Dec. Dig. § 817[3].)

Appeal from St. Louis Circuit Court; James E. Withrow, Judge.

"Not to be officially published."

Action by Lillian Hoette against the North American Union. Judgment for plaintiff, and defendant appeals. Affirmed.

Martin T. Farrow, of St. Louis, for Appellant.
John Cashmann, of St. Louis, for Respondent.

* Decision rendered, July 5, 1916. Rehearing denied, July 18, 1916. 187 S. W. Rep. 790.

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ORDELHEIDE *vs.* MODERN BROTHERHOOD OF AMERICA. (No. 16841.)*

(Supreme Court of Missouri, Division No. 1.)

1. INSURANCE—MUTUAL BENEFIT ASSOCIATION—SUICIDE—“LEGAL REPRESENTATIVES.”

Where a fraternal beneficiary association was chartered under a law of another state, limiting beneficiaries to husband, wife, relative, “legal representatives, heir or legatee” of members, its certificate, payable to “legal representatives,” not being authorized by and therefore not included within, the exemption of Rev. St. 1909, § 7109, as to fraternal beneficiary associations, providing that payments of death benefits shall be to the families, heirs, blood relatives, affianced husband or affianced wife, or to persons dependent upon the member, and that such associations shall be exempt from the provisions of the insurance laws, was an insurance policy to which, by direct provisions of section

* Decision rendered, July 3, 1916. 187 S. W. Rep. 1193.

6945, suicide was no defense, unless it was not shown that insured contemplated suicide when taking out the policy, although the association was licensed to do business in Missouri as a fraternal beneficiary association, since the statute, not the license, is the true test, and since the term "legal representatives" must be construed to mean personal representatives, and not "heirs," in view of the language of the law under which the association was chartered, which used both the terms "legal representatives" and "heirs" to denote different classes.

(For other cases, see *Insurance*, Cent. Dig. § 1956; Dec. Dig. § 788[1].)
(For other definitions, see *Words and Phrases*, First and Second Series, Legal Representative.)

2. INSURANCE—MUTUAL BENEFIT ASSOCIATION—BENEFICIARIES—LEGAL REPRESENTATIVES OF BENEFICIARY.

The proceeds of a fraternal beneficiary association, certificate payable to "legal representatives," go to the estate of deceased member.

(For other cases, see *Insurance*, Cent. Dig. § 1973; Dec. Dig. § 795.)

Appeal from Circuit Court, Warren County; James D. Barnett, Judge.
Action by F. A. Ordelheide, administrator, against the Modern Brotherhood of America. Judgment for plaintiff affirmed by St. Louis Court of Appeals (139 S. W. 269), and case certified to the Supreme Court. Affirmed.

Ball & Sparrow, of Louisiana, Mo., for Appellant.
Emil Roehrig, of Warrenton, for Respondent.



**MODERN BROTHERHOOD OF AMERICA vs. BESHARA.
(No. 7571.)***

(Supreme Court of Oklahoma.)

2. INSURANCE—ACTION FOR DEATH BENEFIT—INSTRUCTIONS—"GOOD HEALTH."

Instructions examined, and *held* to fully state the law applicable.

(For other cases, see *Insurance*, Cent. Dig. § 2010; Dec. Dig. § 826[1].)

(For other definitions, see *Words and Phrases*, First and Second Series, Good Health.)

3. INSURANCE—ACTION FOR DEATH BENEFIT—INSTRUCTIONS—GOOD HEALTH—QUESTION FOR JURY.

The trial court properly refused to direct a verdict for defendant.

(For other cases, see *Insurance*, Cent. Dig. § 2009; Dec. Dig. § 825[2].)

Commissioners' Opinion, Division No. 3. Error from Superior Court, Muskogee County; H. C. Thurmond, Judge.

Action by Schickery Beshara against the Modern Brotherhood of America. Judgment for plaintiff, and defendant brings error. Affirmed. See, also, 42 Okl. 684, 142 Pac. 1014.

* Decision rendered June 20, 1916. 158 Pac. Rep. 613. Syllabus by the Court.

N. B. Maxey, of Muskogee, for Plaintiff in Error.
S. V. O'Hare, of Muskogee, and A. A. Davidson, of Tulsa, for Defendant in Error.

FASS VS. ATLANTIC LIFE INS. CO. (No. 9413.)*

(Supreme Court of South Carolina.)

1. INSURANCE — AGENTS — RENEWAL COMMISSIONS — CONTRACT—CONSTRUCTION.

Contract of insurance agency construed, and *held* to entitle agent to renewal commissions only during the continuance of his employment by the insurance company.

(For other cases, see Insurance, Cent. Dig. § 112; Dec. Dig. § 84[4].)

2. INSURANCE—AGENCY CONTRACTS—DETERMINATION AT WILL.

A life insurance agency contract which fixes no date or time for its duration, and in which the agent has no coupled interest in the subject-matter is determinable at will, regardless of the agent's understanding to the contrary.

(For other cases, see Insurance, Cent. Dig. § 104; Dec. Dig. § 79.)

4. INSURANCE—AGENCY CONTRACTS—RENEWAL COMMISSIONS.

Under an insurance agency contract expressly providing that agent's right to renewal commissions should continue only while he remained in the employment of his principal, such agent had no coupled interest in the agency such as would prevent the principal from revoking his authority at will.

(For other cases, see Insurance, Cent. Dig. § 104; Dec. Dig. § 79.)

7. INSURANCE—AGENCY—RENEWAL COMMISSIONS—RECOVERY BY AGENT AFTER TERMINATION OF HIS EMPLOYMENT.

Where insurance company induced agent to remain in its employment by representations that his renewal commissions would support him and his family in their old age, *held* the written contract of agency was so modified as to entitle the agent to renewal commissions after revocation of his agency without cause.

(For other cases, see Insurance, Cent. Dig. § 112; Dec. Dig. § 84[4].)

Appeal from Common Pleas Circuit Court of Dillon County; Hayne F. Rice, Judge.

Action by Max Fass against the Atlantic Life Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

* Decision rendered, June 30, 1916. 89 S. E. Rep. 558.

GREGORY *vs.* SOVEREIGN CAMP OF WOODMEN OF THE WORLD.—THOMPSON *vs.* SAME. (No. 9430.)*

(Supreme Court of South Carolina.)

1. INSURANCE—MUTUAL BENEFIT—CHANGE OF BENEFICIARY—WHAT LAW GOVERNS.

Assured's change of beneficiary to one who was not a relative, but supported him, is void where prohibited by a statute of Nebraska, where the insurer was organized, although Civ. Code 1912, § 2752, allows such a change if the insurer consents.

(For other cases, see Insurance, Cent. Dig. §§ 1933, 1937; Dec. Dig. 770.)

2. INSURANCE—MUTUAL BENEFIT—BENEFICIARIES—RIGHT TO CHANGE.

Under an Alabama statute allowing a fraternal insurance association to limit, by its laws, the scope of its beneficiaries, assured's change of beneficiary is void, where forbidden by the association's constitution and the laws of Nebraska, where it was organized.

(For other cases, see Insurance, Cent. Dig. §§ 1932, 1937, 1938; Dec. Dig. § 769.)

3. INSURANCE—MUTUAL BENEFIT—WHO MAY BE BENEFICIARIES—STATUTE—WAIVER.

A fraternal insurance association cannot waive a restriction as to beneficiaries imposed by the statutes of the state where it was organized.

(For other cases, see Insurance, Cent. Dig. §§ 1933, 1937; Dec. Dig. § 770.)

Appeal from Common Pleas Circuit Court of Union County; Ernest Moore, Judge.

Actions by Mrs. S. E. Gregory and by J. E. Thompson against the Sovereign Camp of Woodmen of the World. From judgments against the first-named plaintiff and in favor of plaintiff Thompson, said Gregory and defendant appeal. First judgment affirmed, and second reversed.

J. Ashby Sawyer, of Union, and Quattlebaum & Cochran, of Anderson, for Appellants.

Wallace & Barron, of Union, for Respondent.

* Decision rendered, July 3, 1916. 89 S. E. Rep. 391.



RELIANCE LIFE INS. CO. *vs.* BEATON. (No. 7564.)*

(Court of Civil Appeals of Texas. Dallas.)

1. INSURANCE—AGENT'S COMPENSATION.

In an action by an insurance agent on bonus contract allowing compensation upon the amount of insurance procured, the words "sixty days allowed for settlement," in the absence of testimony showing the sense

* Decision rendered, June 10, 1916. Rehearing denied, July 1, 1916. 187 S. W. Rep. 743.

in which used, *held* to mean a grace of sixty days after the year covered by the contract in which to allow the parties thereto to settle among themselves the volume of business which had been procured, and not to have reference to the time allowed for the collection or payment of premiums due for such business.

(For other cases, see Insurance, Cent. Dig. §§ 111, 114; Dec. Dig. § 84[1].)

2. INSURANCE—COMPENSATION OF AGENT—ACTION—INSURANCE AGENT—EVIDENCE.

In an action by an insurance agent on a bonus contract, based upon the amount of insurance procured during the year, evidence of plaintiff and a telegram from the company near the close of the year stating that his territory had procured \$1,223,000 life insurance business and asking for more business, *held* sufficient to support a finding that the business procured during the year exceeded \$1,250,000.

(For other cases, see Insurance, Cent. Dig. §§ 111, 114; Dec. Dig. 84[1].)

Appeal from District Court, Dallas County; E. B. Muse, Judge.

Action by Ralph A. Beaton against the Reliance Life Insurance Company. From a judgment for plaintiff, defendant appeals. Affirmed.

Harry P. Lawther, of Dallas, for Appellant.

Henry P. Edwards and Cockrell, Gray & McBride, all of Dallas, for Appellee.



**McDONALD vs. AETNA LIFE INS. CO. OF HARTFORD,
CONN. (No. 7182.)***

(Court of Civil Appeals of Texas. Galveston.)

2. INSURANCE — LIFE INSURANCE — COMPROMISE — GOOD-FAITH CONTROVERSY.

All that is required to validate a compromise on a life policy is that the beneficiary understand the settlement and that the insurer act in good faith in disputing the claim, and the ground of dispute need not be brought home to the beneficiary.

(For other cases, see Insurance, Cent. Dig. §§ 1417, 1419; Dec. Dig. § 579.)

Appeal from District Court, Galveston County; Robt. G. Street, Judge.

Action by Mrs. Minnie E. McDonald against the Aetna Life Insurance Company of Hartford, Conn. Judgment for defendant, and plaintiff appeals. Affirmed.

King & Hughes, of Galveston, Harry Tom King, of Abilene, and H. C. Hughes and R. L. Pillow, Jr., both of Galveston, for Appellant.

Baker, Botts, Parker & Garwood and Jno. C. Townes, Jr., all of Houston, and W. T. Armstrong, of Galveston, for Appellee.

* Decision rendered, May 25, 1916. Rehearing denied, June 29, 1916. 187 S. W. Rep. 1005.

MODERN WOODMEN OF AMERICA *vs.* YANOWSKY.
(No. 5628.)*

(Court of Civil Appeals of Texas. San Antonio.)

1. INSURANCE — FRATERNAL ASSOCIATIONS — ACTION ON POLICY—PARTIES.

In a suit on a certificate of a fraternal association originally payable to plaintiff's father and mother, wherein plaintiff claimed to own all their interests by virtue of assignment from the heirs of her father, the failure to make her father a party was not error, where it appeared that he was dead.

(For other cases, see Insurance, Cent. Dig. § 1994; Dec. Dig. § 813.)

Error from District Court, Bexar County; R. B. Minor, Judge.

Action by Minnie Yanowsky, as assignee of Rosie Yanowsky and of the heirs of Shopsy Yanowsky, the beneficiaries named in a policy of insurance, against the Modern Woodmen of America. Judgment for plaintiff, and defendant brings error. Reversed in so far as the judgment affects the interest claimed from Shopsy Yanowsky, and cause remanded.

Truman Plantz, of Warsaw, Ill., and Pat M. Neff, of Waco, for Plaintiff in Error.

Arnold, Cozby & Peyton, of San Antonio, for Defendant in Error.

* Decision rendered, April 19, 1916. On motion for rehearing, May 31, 1916. Rehearing denied, June 21, 1916. 187 S. W. Rep. 728.



AMERICAN NAT. INS. CO. *vs.* NUCKOLS. (No. 5686.)*

(Court of Civil Appeals of Texas. San Antonio.)

1. INSURANCE—LIFE INSURANCE—PROOF OF LOSS—ESTOPPEL—POWER OF AGENT.

Where the company agent was notified of death and viewed the body and said he was satisfied and that the loss would be paid, and the adjuster recognized his authority until suit was brought, and then denied it, the company was estopped to deny the agency.

(For other cases, see Insurance, Cent. Dig. § 1412; Dec. Dig. § 565.)

2. INSURANCE — LIFE INSURANCE — PROOF OF LOSS — AUTOPSY—TIME.

Where the policy gave the insurer the right to an autopsy, but it was not demanded at the time of death, the insurer could not, six weeks after interment, insist on such right, especially where it was undisputed that the insured died by an accident covered by the policy and the only dispute was whether his neck was broken or dislocated.

(For other cases, see Insurance, Cent. Dig. § 1356; Dec. Dig. § 549.)

* Decision rendered, June 7, 1916. Rehearing denied, June 27, 1916. 187 S. W. Rep. 497.

3. INSURANCE — LIFE INSURANCE — PROOF OF LOSS — AUTOPSY—TIME—EXHUMATION.

To give the insurer the right of exhumation of the insured's body, such right must be clearly expressed in no uncertain words in the policy.

(For other cases, see Insurance, Cent. Dig. § 1356; Dec. Dig. § 549.)

4. INSURANCE — LIFE INSURANCE — PROOF OF LOSS — AUTOPSY—TIME—EXHUMATION.

Insurer's right to exhume insured's body, if covered by right to autopsy, can be exercised only at once and upon showing that it will show fraud or mistake.

(For other cases, see Insurance, Cent. Dig. § 537; Dec. Dig. § 249.)

5. INSURANCE — LIFE INSURANCE — PROOF OF LOSS—AUTOPSY—TIME—EXHUMATION.

Where insurer pleaded that doctors' conflicting statements that insured died from broken neck, and from dislocated neck, meant the same thing, it could not base its right to an autopsy on such conflicting statements.

(For other cases, see Insurance, Cent. Dig. § 1356; Dec. Dig. § 549.)

Appeal from District Court, Travis County; Charles A. Wilcox, Judge. Action by Maggie Nuckols against the American National Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Williams & Neethe, of Galveston, and N. A. Stedman, of Austin, for Appellant.

S. W. Fisher, N. A. Rector, and Robt. L. Thompson, all of Austin, for Appellee.

FIRE, TORNADO, ETC.**UNITED STATES CIRCUIT COURT OF APPEALS.
FOURTH CIRCUIT.**

SPRING GARDEN INS. CO. OF PHILADELPHIA, PA.,

vs.

WOOD. (No. 1398.)*

1. INSURANCE—FIRE POLICIES—ACTIONS—JURY QUESTION.
In an action on a fire policy upon a building in which the agent writing the policy had an interest, the question whether the insurer was notified of the agent's interest, *held* for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1737-1740, 1758-1760; Dec. Dig. § 668[5].)

2. INSURANCE—FIRE INSURANCE—ACTIONS—JURY QUESTION.

In an action on a fire policy upon property in which the agent had an interest, the question whether the agent, in attaching a rider allowing other insurance without permission of the insurer, acted fraudulently, and whether other insurance avoided the policy, *held* for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1737-1740, 1758-1760; Dec. Dig. § 668[6].)

Dayton, D. J., dissenting.

In Error to the District Court of the United States for the Eastern District of Virginia, at Richmond; Edmund Waddill, Jr., Judge.

Action by T. Gilbert Wood, suing for the benefit of himself, the Roanoke Sheet Metal Company, and J. D. Wood, against the Spring Garden Insurance Company of Philadelphia, Pa. There was a judgment for plaintiff, and defendant brings error. Affirmed.

Before Knapp and Woods, C. JJ., and Dayton, D. J.

George Bryan, of Richmond, Va., and Gustavus Remak, Jr., of Philadelphia, Pa., for Plaintiff in Error.

James R. Caskie and George E. Caskie, both of Lynchburg, Va., for Defendant in Error.

Woods, C. J.

There have been three trials of this action on a fire insurance policy issued by the plaintiff as agent of the defendant company on his own property.

Two defenses were relied on at the first trial: (1) The condition that the policy would be avoided by other insurance; and (2) the failure of the plaintiff as agent of the defendant company to notify it that he was the owner of the property. After

* Decision rendered, May 2, 1916. 233 Fed. Rep. 223.

hearing the evidence the District Court refused to direct a verdict in favor of the defendant, and the jury found for the plaintiff. This court held that, the plaintiff having reported the policy issued to "Haytakah Inn" as the owner, and having failed to show that his principal was advised as to his ownership, he could not recover. It was on this ground alone that the case was sent back for a new trial. On the second trial the defendant abandoned the first defense and relied entirely on the second. The District Judge on the second trial directed a verdict for the defendant. On writ of error this court found the evidence of notice to defendant's special agent Young of plaintiff's ownership of the property and of Young's authority to represent the defendant, materially stronger than that offered on the first trial and sufficient to raise an issue for the jury whether the defendant did not accept the risk with notice of Wood's ownership. The cause was accordingly remanded for a new trial. On the third trial the defendant reinstated without objection the defense of subsequent insurance contrary to the terms of the policy, and in addition relied again on the defense that the plaintiff as agent of the defendant had insured his own property without notice to his principal of his ownership. At the close of the evidence the District Judge refused to direct a verdict for the defendant, and the jury again returned a verdict in favor of the plaintiff for the amount claimed. The first question is whether the defendant was entitled to a directed verdict.

[1] As to the defense that the plaintiff failed to notify the defendant of his ownership of the property, the evidence varied little from that which this court had held sufficient to require the submission of the issue of notice to the jury, except in one particular. The defendant produced from its own possession at the last trial a copy of a line sheet indicating in writing the property which the special agent, Young, had authorized the plaintiff to insure, and on that the hotel property does not appear. Young testified that the original of this line sheet was either left with Wood or sent to him from the company's office. Wood denied that he had ever received the line sheet, and testified, on the contrary, that his instructions were verbal, and that Young, with full notice that he had an interest in the hotel, authorized and encouraged him to insure it. This testimony made a square issue of fact for the jury between Young and Wood on a material point.

It seems clear from these considerations, in addition to what was said in the former opinions, that the trial judge could not properly take the case from the jury on the ground that there could be no reasonable difference of opinion that Wood had insured his own property without the knowledge or the consent of his principal.

[2] The other important point presents greater difficulty. In the report sent in by Wood of the policy for \$2,500 sued on he noted the fact that there was \$7,000 other insurance outstanding;

but he failed to note that a rider containing the three-fourths clause which related to additional insurance had been attached to the policy. He received a request from the company by letter of January 31, 1910, to attach "three-fourths value and fire protection clauses." Wood testified he thought it unnecessary to answer defendant's letter, as he found on examination that the three-fourths value rider had been attached. After the policy sued on was issued he took out additional insurance in another company to the amount of \$2,000; and it is this additional insurance which the defendant claims avoided the policy.

The slip attached to the policy known as "Form 204" allowed other insurance without permission of the company. At this time Wood had in his possession forms of slip No. 219, which allowed additional insurance only on permission of the company. The point pressed by the defendant is that it was Wood's duty to attach the latter form of slip, which would have denied him the right to take out additional insurance without notice to the company and its permission, and that his failure to do so, coupled with the fact that additional insurance was taken out without notice to the company annulled the contract. We think this inference depends on the good faith of Wood. It is true that he did attach form 219 to the other policies issued by him, and that good business methods required that in making his report he should indicate that a three-fourths clause allowing additional insurance had been attached and the form he had used. The argument is strong that Wood failed in his duty to the company when he attached to the policy the form 204 allowing additional insurance and said nothing more to the company about it after receiving its letter on the subject. But, on the other hand, there is reason in Wood's explanation that the form 219 on its face seemed to be intended to apply to a policy on household furniture, while this policy was on an unfinished building without furniture. He was a school teacher and untrained in the insurance business, which the defendant's special agent had solicited him to undertake. The defendant had furnished him the form of slip he used, and had not withdrawn it, nor instructed him not to use it, nor to use form 219. These are strong considerations in favor of the inference of entire good faith, and of his error from the negligence of the company in supplying him with forms it did not intend he should use, and in failing to give him instructions as to the proper slips to be attached. The issues of fact on the two defenses set up were therefore properly submitted to the jury.

[3] The charge, it is true, did not emphasize the point of view of the defendant on these issues; but the District Judge did instruct the jury that, for the plaintiff to recover, they must believe from the evidence that the plaintiff acted in good faith in attaching to the policy a form allowing additional insurance which had been furnished him by the company; that Young, the special

agent, was advised that the policy about to be issued covered the plaintiff's property, or property in which he had an interest; that Young was fully authorized to act for the company, and was the only representative of the company in the state of Virginia known to the plaintiff; that the plaintiff had acted with the utmost frankness and good faith in all the matters relating to the issuance of the policy; and that unless the plaintiff had made out his case in all material particulars by the preponderance of the evidence the verdict should be for the defendant. This covered the law of the case. The requests of the defendant merely elaborated and emphasized the defendant's view of the issues, and their rejection is not sufficient ground for a new trial.

[4] There was no reversible error in the refusal to receive as evidence plaintiff's reports of other policies to the stamping office, since the plaintiff admitted as true all that would have appeared from these reports.

[5] The question asked Young as to whether he would have accepted the policy, had he known of Wood's ownership, was properly excluded. The plaintiff could not be bound by what Young now says he would have done. The material inquiry was what the company actually did, in view of the alleged information given by Wood to Young that he was the owner.

The case is one of difficulty, but consideration of the evidence offered tending to show Wood's good faith, knowledge of the material facts by the special agent of the insurance company, the negligence of the company in making Wood's mistake possible by leaving form No. 204 in his hands as if for use, and the company's failure to furnish him with instructions, together with the fact that two juries have found the issues of fact against the defendant, leads to the conclusion that it would be going too far to say that no reasonable inference on the vital issues could be drawn in favor of the plaintiff.

Affirmed.

Dayton, D. J., dissents.

SUPREME COURT OF NEW YORK.

TRIAL TERM, ERIE COUNTY.

BUSE

vs.

NATIONAL BEN FRANKLIN INS. CO. OF PITTSBURGH, PA.

SAME

vs.

MILLERS' NAT. INS. CO. OF CHICAGO, ILL.

SAME

vs.

NORTHWESTERN NAT. INS. CO. OF MILWAUKEE, WIS.*

1. INSURANCE—FIRE INSURANCE—APPORTIONMENT OF LOSS.

Where there were three policies of insurance, each covering buildings on six distinct parcels of land, and a coinsurer of part had voluntarily compromised and paid its share of the loss, the liabilities of the other companies may be determined from the provisions of the policies, without reference to the compromise payment, if the aggregate payments do not exceed the loss.

(For other cases, see Insurance, Cent. Dig. §§ 1285-1290; Dec. Dig. § 504.)

2. INSURANCE—FIRE INSURANCE—"COINSURANCE."

"Coinsurance" is a relative division of risk between the insurer and the insured, dependent upon the relative amount of the policy and the actual value of the property insured, and taking effect only when the actual loss is partial and less than the amount of the policy; the insurer being liable to the extent of the policy for a loss equal to or in excess of that amount.

(For other cases, see Insurance, Cent. Dig. §§ 1270-1272; Dec. Dig. § 495[1].)

3. INSURANCE—FIRE INSURANCE—CONSTRUCTION OF POLICY—APPORTIONMENT.

Where a blanket fire policy, providing for apportionment and coinsurance, covered six distinct buildings, for an entire sum, and a loss occurred on a number of them, the liability for the loss will be computed in proportion to the total value of all the buildings, and not the value of those burned, since the latter construction would destroy the effect of the coinsurance provision, and leave the parcels on which no loss occurred without insurance.

(For other cases, see Insurance, Cent. Dig. §§ 1285-1290; Dec. Dig. § 504.)

4. INSURANCE—FIRE INSURANCE—STRAIGHT POLICY.

Under a policy of ordinary or "straight" insurance, the value of the property is not important, if not less than the amount of the insurance.

* Decision rendered, July 20, 1916. 160 N. Y. Supp. 566.

since, if the loss is total, and the value of the property equals or exceeds the amount of the insurance, the insurer is liable for the full amount of the policy, and, in case of partial loss, is liable for the amount of the loss.

(For other cases, see Insurance, Cent. Dig. § 1274; Dec. Dig. § 499.)

5. INSURANCE—FIRE INSURANCE—APPORTIONMENT OF LOSS—OTHER INSURANCE.

In an action on three blanket policies, containing provisions for apportionment and coinsurance, covering six distinct buildings, where another company issued a similar policy insuring two buildings, and, by adding together the full amount of liability on these buildings of the defendant companies and the other company, the insured will in no instance receive the full amount of his loss, there will be no apportionment, since the insured is entitled to the greatest protection possibly consistent with the provisions of the policy, and the coinsurance clause fixes the method of apportionment.

(For other cases, see Insurance, Cent. Dig. §§ 1285-1290; Dec. Dig. § 504.)

Actions by Gus G. Buse against the National Ben Franklin Insurance Company of Pittsburgh, Pa., against the Millers' National Insurance Company of Chicago, Ill., and against the Northwestern National Insurance Company of Milwaukee, Wis., respectively, consolidated for trial. Judgment for plaintiff.

The three above entitled actions, involving the same questions, were tried together before the court, without a jury, at the March, 1916, term of the Erie County Supreme Court.

Gibbons & Pottle, of Buffalo (Frank Gibbons, of Buffalo, of counsel), for Plaintiff.

Shire & Jellinek, of Buffalo (Vernon Cole, of Buffalo, of counsel), for Defendant.

ROWLAND L. DAVIS, J.

The plaintiff, the owner of six parcels of property, known as 851, 853, 855, 857, and 851-853 rear Sycamore street, and 876 Fillmore avenue, in the city of Buffalo, obtained blanket policies of insurance covering the property, aggregating \$8,000, as follows: In the National Ben Franklin Insurance Company of Pittsburgh, Pa., a policy of \$3,000; in the Northwestern National Insurance Company of Milwaukee, Wis., \$3,000; in the Millers' National Insurance Company of Chicago, Ill., \$2,000. The policies are what are known as "full coinsurance policies." The terms and provisions of these policies were identical, except as to the difference in the amount, as stated. The plaintiff had procured another insurance policy issued by the Sun Insurance Office, which covered parcels 851-853 rear, 853, and 855, each in the sum of \$500, aggregating \$1,500. This policy also was a full coinsurance policy, identical in its provisions in that respect to the other policies. These provisions are as follows:—

"This company shall not be liable for a greater proportion of any loss or damage to the property described herein than the sum hereby insured bears to one hundred per centum (100%) of the actual cash value of said property at the time such loss shall happen."

All of the policies also contained an apportionment clause in the following language:—

"This company shall not be liable under this policy for a greater proportion of any loss on the described property, or for loss by and expense of removal from premises endangered by fire, than the amount hereby insured shall bear to the whole insurance, whether valid or not, or by solvent or insolvent insurers, covering such property, and the extent of the application of the insurance under this policy, or of the contribution to be made by this company in case of loss, may be provided for by agreement or condition written hereon or attached or appended hereto."

While the policies were in force on the 8th of July, 1915, a fire caused damage to the parcels known as 851, 853, 851-853 rear, and 855 Sycamore street. No damage resulted to 857 Sycamore street or 876 Fillmore avenue. The damage as to the other property was partial only as to each, and in varying amounts.

Pursuant to the terms of the policy, an appraisal was had, fixing the sound value of all of the property insured, both injured and uninjured, and the amount of loss on each separate parcel. This appraisal has been accepted by both parties as correct, and the items of value and of loss are as follows: 851 Sycamore street, sound value \$3,070, loss \$389.50; 853 Sycamore street, sound value \$1,272, loss \$497.07; 855 Sycamore street, sound value \$1,610, loss \$254.47; 851-853 rear Sycamore street, sound value \$2,112, loss \$1,625.70; 857 Sycamore street, sound value \$4,500, loss nothing; 876 Fillmore avenue, sound value \$2,150, loss nothing. The total sound value of all the property was \$14,714, and the total loss \$2,766.74. The total sound value of the four parcels of property sustaining loss was \$8,064.

From the foregoing statement of facts, it will be readily seen that the situation is somewhat confusing; and (1) to interpret the policies in relation to their respective liabilities for the losses sustained, and (2) to apportion those losses between the companies insuring the whole property, and the company insuring only a portion, are the somewhat perplexing problems presented.

[1] It appeared upon the trial that the loss had been adjusted with the Sun Insurance Office, and an amount had been paid by that company under its policy, as claimed by the plaintiff, in compromise of its liability. The amount actually paid by the latter company, it seems to me, is immaterial as long as it was paid voluntarily, and that company is not seeking contribution. The liability of the defendant companies may be determined from the provisions of the policies themselves without reference to any amount actually paid by the Sun Insurance Office in compromise or settlement of its liability, at least if the aggregate payments do not exceed the loss. *Lucas vs. Jefferson Ins. Co.*, 6 Cow. 635. As already stated, the blanket policies issued by the three defendants were in the form of what is known as "full or 100 per cent coinsurance."

[2] The first question at issue between the parties is as to the amount of liability which defendants sustained toward the parcels of property injured; the claim of the plaintiff being that the total amount of the policy is applicable to the payment of the loss sustained on the four injured parcels, although it, by its terms, also covered the two that were uninjured—in other words, that these parcels of the value of \$8,064 are practically fully insured by the policies aggregating \$8,000. This contention is denied by the defendant. In reaching an understanding of this question, which will be the first considered, it will be necessary to formulate a legal definition and statement of what coinsurance means. Coinsurance means a relative division of the risk between the insurer and the insured, dependent upon the relative amount of the policy and the actual value of the property insured thereby. In full or 100 per cent coinsurance, if the value of the property equals or is less than the face of the policy, the risk is entirely upon the insurer. If the value of the property exceeds the face of the policy, then the insurer and the insured assume the risk in the ratio of the face of the policy to the excess in value.

[3, 4] The parties may not know the actual value of the property at the time it is insured, and therefore agree upon an arbitrary sum as its value rather than go to the trouble and expense of making an accurate appraisal of the property; or it may be that the value of the property may undergo change, and increase during the term of the policy; and when a loss occurs, and the sound value of the property is determined at that time, it may turn out that the actual value was considerably in excess of the arbitrary value fixed in the policy. Then by the terms of the policy the insured becomes liable for his proportion of the risk, to wit, the amount of such excess. Where the loss is total, the problem is simple; the company pays the total amount of the insurance, and the insured bears the burden of the remainder of the loss. It would seem that where the loss is partial, under the same circumstances, the reasonable construction would be that the two coinsurers should share the loss in the same proportion.

There seems to have been no definition given nor a definite statement made of the liabilities of the parties to a policy of coinsurance by the courts of this state, particularly where the loss was partial, so far as I can discover, where the question was directly presented. In Richards on Insurance, page 301, it is said:—

"The object of the coinsurance clause is to compel the insured to take out insurance to the designated percentage of the value of his property, usually either 80 or 100 per cent, or else become his own insurer to the amount of the deficiency, and the average clause applies where property is insured as an entirety, though located in several places or buildings in proportions perhaps unknown to the insurers, or in shifting proportions, and its object

is to ratably distribute the insurance over all the properties, so that, in case of a loss in one place, the insured cannot call upon the total amount, but only the ratable amount of insurance for contribution to such a localized loss."

In discussing the question as to what is the meaning of "whole insurance," Vann, J., says, in *Farmers' Feed Co. vs. Scottish Union Ins. Co.*, 173 N. Y. 241, at page 247, 65 N. E. 1105, at page 1107 (speaking of 80 per cent coinsurance) :—

"Thus the effect of the coinsurance clause is that if the property is insured to 80 per cent of its value, or more, in case of a total loss the whole sum insured becomes due, but with insurance for less than 80 per cent of the value, and a loss also of less than 80 per cent, the owner becomes, in effect, a coinsurer proportionately. He could have procured insurance to 80 per cent of the value, but, not having done so, he becomes his own insurer pro tanto. This accords with the way the clause is characterized in the policies, for it is entitled 'percentage coinsurance clause,' which means insurance by the company and the owner, depending upon the percentage or proportion which the insurance bears to the value. The object is through lower premiums to induce the owner either to take out insurance to 80 per cent of value, or to become a coinsurer with less risk to the company in case of a loss falling below such percentage of value. Whether either the loss or the insurance equals or exceeds 80 per cent of the value, the clause has no effect; but, when both are less, the insured and the insurer bear the loss in certain proportions."

But the learned counsel for the plaintiff contends that, in the case of a blanket policy covering several distinct parcels, the rule is different; that the plaintiff is entitled to apply the total amount of insurance, to wit, the face of the policies, to the particular parcels which have sustained loss, and, as the value of these parcels does not exceed the face of the policies, the plaintiff is entitled to recover the full amount of either total or partial loss sustained on each of these particular parcels of property. He relies largely upon the statement in the opinion of Rapallo, J., in *Ogden vs. East River Ins. Co.*, 50 N. Y. 388, at page 392 (10 Am. Rep. 492), where it is said:—

"By insuring several parcels of property for an entire sum the insured obtains the advantage, and the insurer subjects himself to the liability, of having so much of the total sum insured as may be necessary to compensate for damage to any part of the property applied to that part, though the sum named in the policy would have been insufficient to cover the loss, if the whole had been destroyed. Thus it is left to the result in case of a partial loss, to determine what sum is insured upon any particular parcel, the only limit being its value."

In rejecting the doctrine quoted, as applicable to this case, it may first be noted that the language of the learned court was purely obiter. He had already decided the question of apportion-

ing the loss between the blanket policies and the specific policy issued by the defendant, and the case involved a total loss, where it was held there was no occasion for any apportionment; and, following the language quoted and relied upon by the plaintiff's counsel, the court says:—

"We refrain from expressing an opinion now upon the several phases which might be developed under an insurance of this character in case of partial loss, confining our adjudication to the case before us, which was that of a total loss of the whole subject insured by the policies."

It may be noted that the policies under discussion were not coinsurance policies.

The learned counsel also relies upon the authority of *Lesure Lumber Co. vs. Mutual Ins. Co.*, 101 Iowa, 514, 70 N. W. 761, and *Page vs. Sun Ins. Co.*, 74 Fed. 203, 20 C. C. A. 397; 33 L. R. A. 249. The question in each instance before the court was the second question involved in the case at bar, to wit, the apportionment of the loss between the insurance companies having respectively blanket and specific policies on parcels of property sustaining loss. In determining the respective liabilities of the companies, it was held in those cases that, where several parcels of property were insured by blanket insurance and one parcel by specific insurance, the total amount of the policy of blanket insurance was applicable to the parcel injured covered by specific insurance. If this was the correct rule in determining the apportionment of loss between two companies, it ought, of course, to be the correct rule of liability as between the insured and the company issuing the blanket policy. The error into which the learned counsel has fallen, it seems to me, is in not noting the distinction between the terms of the policies. The policies in the cases cited did not contain the coinsurance clause. The coinsurance form is apparently modern. *Richards on Insurance*, 442, note.

The rule contended for by counsel might be the correct one, if the policy was one of ordinary or "straight" insurance. Under such policies the value of the property is not important, as long as it is not less than the amount of the insurance. In such case, if the loss is total, and the value of the property equals or exceeds the amount of the insurance, the company is liable for the full amount of the policy. In case of partial loss, the company is liable to the amount of the loss. In 19 Cyc. 838, it is said:—

"In case of partial loss, the company is liable under the ordinary policy to pay the full damage up to the amount of the insurance; but it may be provided in the contract that the insured shall carry a part of the risk and the company shall assume the risk as to a portion only of the value of the property" (*citing Farmers' Feed Co. vs. Scottish Union Ins. Co., supra*).

Under the coinsurance policy, the company does restrict its liability. To adopt the rule contended for by plaintiff would be

to exempt entirely the insured from any liability as to coinsurance, except when the loss was total. It would leave portions of the property without insurance, for if the four parcels in question had been totally destroyed, and if, as the plaintiff contends, the insurer was liable for the full amount of the policy, to be applied on those parcels, the effect would be to leave the other two without insurance. In *Ogden vs. East River Ins. Co.*, *supra*, Rapallo, J., says:—

“Where several parcels of property are insured together for an entire sum, it is impossible to say as to either of the parcels that there is no insurance upon it.”

If there had been total loss of the four parcels, and no loss on either of the other two parcels, under the doctrine advocated by counsel, the plaintiff would then have the total amount of his insurance and the remaining amount of his property with its value entirely unimpaired, and he would in no sense be a coinsurer. In other words, the plaintiff would never be a coinsurer, except in the event of a total loss of all the parcels covered by the blanket policies. This would do a violence to the reasonable interpretation of contracts, which it seems to me cannot be justified. I am not unmindful of the rule that:—

“Of two admissible constructions of an insurance contract the one against the insurers should be preferred, since they dictate its form and are the authors of its ambiguity” (*Imperial Shale Brick Co. vs. Jewett*, 169 N. Y. 143, 62 N. E. 167), and that “any uncertainty in the language of a fire insurance policy will be resolved in favor of the insured” (*Maisel vs. Fire Association*, 59 App. Div. 461, 69 N. Y. Supp. 181; 19 Cyc. 656).

But it seems to me there is no ambiguity, and we must adopt the principle laid down in *Allen vs. German-American Ins. Co.*, 123 N. Y. 6, 25 N. E. 309, that:—

“A policy of insurance forms no exception to the general rule that contracts will be enforced according to their terms, and effect will be given to the expressed and evident intention of the parties.”

In Richards on Insurance, page 301, it is said:—

“In the absence of a coinsurance clause, the assured collects his whole loss, if that does not exceed his insurance, and his whole insurance, if that does not exceed his loss. With a coinsurance clause present, the foregoing rule of recovery is modified, and the recovery reduced, but only if the insurance and the loss are both below the percentage of value, usually 80 or 100 per cent, as named in the clause.”

I therefore reach the conclusion that the liability as to the defendant companies on the partial loss sustained on the property injured is represented by the proportion as \$14,714, the value of the property, is to \$8,000, the amount of the insurance, so is \$2,766.74, the total amount of loss on the four parcels, to the

amount required, to wit, \$1,504.28, the sum for which the defendant companies are obligated.

[5] There remains to be considered the question of what, if any, apportionment should be made between the defendant companies and the Sun Insurance Office, which had what has been called "specific insurance" on three of the parcels injured. Perhaps no question has led to a greater confusion in the courts than the questions arising in what is known as "nonconcurrent or partially concurrent apportionments." In a very able discussion of the subject in a footnote in Richards on Insurance (3d Ed.), page 440, written by Mr. Willis O. Robb, it is stated that there are at least six different rules which courts in different jurisdictions have adopted, and which Mr. Robb summarizes in the comment that:

"No one of them is either demonstrably sound in theory or universally applicable in practice."

He calls attention to the fact that these rules were all made in reference to the ordinary or open insurance policy, and that the advent of the coinsurance clause has tended to discredit all the rules that had theretofore been applied to apportionment of loss among nonconcurring or partially concurring policies.

In deciding that the policies of the defendant companies should be interpreted so that the coinsurance clause applies to cases of partial loss on separate parcels of property, and that the insurer shares the risk for the excess of value of the property beyond the amount of the policy applicable thereto, it is difficult to understand on any rational theory how it may concern the defendant companies whether the insured carries the remaining risk himself or, for his own protection, shares that risk with some other company by taking out additional insurance. We must keep in mind the fact that the policy in the Sun Company was also a coinsurance policy. Applying the same principle of determining liability to the Sun policy that we have adopted for the defendants' policies, we find that on parcel No. 853, where the value of the property was \$1,272, the amount of the insurance on this property was \$500, the loss \$497.07, and the liability of the Sun policy will be $\frac{500}{1272}$ of the loss, or \$195.40. Similarly, on parcels No. 855 and 851-853 rear, its liability would be, respectively, \$79.03 and \$384.82.

The liability of the defendant companies on the same three parcels for the loss sustained is, respectively, on No. 853, \$270.26; on No. 855, \$138.35; on Nos. 851-853 rear, \$883.89. By adding together the items of liability of the Sun Company and of the defendant companies on each of the three parcels, we find that, if all the companies are held to the limit of their liability, the insured will in no instance, receive the total amount of his loss.

There is a well-recognized principle of insurance, as determined by the courts, that the insured should be given the greatest protection possibly consistent with the provisions of the policy.

In discussing the question of the confusion in the law regarding apportionment, in Richards on Insurance, at page 438, it is said:—

"One principle, however, the courts seem to hold in common, is this, that, unless the express phraseology of the policies prohibits, the contribution clause ought not to be so applied as to diminish the protection of the insured; since usually the insurer fixes the amount of his premium regardless of other insurance, and if, after the fire, he happens to find other insurance which relieves him in part from his liability, it is a piece of pure good fortune. His principal engagement is to pay the loss in full up to the face of his policy, and the insured has given no promise to take out or to keep up other insurance."

If we were to adopt the rule laid down in Farmers' Feed Co. vs. Scottish Union Insurance Co., *supra*, that the defendant companies were entitled to have the apportionment clause interpreted by treating the face of the policy, \$500, as a part of the "whole insurance" on the three separate parcels insured by the Sun Company, the effect would be that, by taking out this additional insurance and paying the premium, the plaintiff would actually have reduced the liabilities of the companies, and would be able to collect only a much smaller percentage of his loss than as though he had taken no additional insurance. This, of course, would be manifestly inconsistent and unjust. The specific insurance in the Farmers' Feed Co. Case was an ordinary open policy, and did not contain the coinsurance clause, as does the policy in the Sun Company, so that rule cannot be deemed applicable here.

It seems to me that under these coinsurance policies the apportionment rule cannot justly be applied, where the amount of the liability of all the companies is less than the actual loss. In commenting on the rule of apportionment adopted in *Blake vs. Exchange Mutual Insurance Co.*, 12 Gray (Mass.) 265, Rapallo, J., in *Ogden vs. East River Insurance Co.*, 50 N. Y. 388, 10 Am. Rep. 492, says:—

"That rule is, in substance, that for the purpose of apportioning the loss in case of overinsurance, where several parcels are insured together by one policy for an entire sum, and one of the parcels is insured separately by another policy, the sum insured by the first-mentioned policy is to be distributed among the several parcels in the proportion which the sum insured by that policy bears to the total value of all the parcels. * * * It is manifest that there was no overinsurance, and that consequently there is no occasion for any apportionment."

So in the case at bar there was no overinsurance on any of these parcels, and I therefore conclude there is no occasion for any apportionment. This conclusion is strengthened by the provisions of the policies in suit. The apportionment clause is in the general standard printed form. The coinsurance clause is one of several riders attached to the policy, partly typewritten and partly printed,

which tend to modify the general provisions of the policy. The latter part of the apportionment clause says:—

“And the extent of the application of the insurance under this policy, or of the contribution to be made by this company in case of loss, may be provided for by agreement or condition written hereon or attached or appended hereto.”

The contribution has been provided for by the coinsurance clause attached, which fixes the liability of the company for the proportion of loss or damage which the face of the policy bears to 100 per cent of the actual cash value of the property. It follows that the total liability under the three policies in suit for the loss on the four parcels of property amounts to \$1,504.28, for which the National Ben Franklin Fire Insurance Company of Pittsburgh, Pa., is obligated to pay three-eighths, or \$564.10; the Northwestern National Insurance Company of Milwaukee, Wis., three-eighths, or \$564.10, and the Millers' National Insurance Company of Chicago, Ill., two-eighths, or \$376.08.

Judgment for the plaintiff accordingly.



ÆTNA INS. CO. ET AL. VS. SHORT. (No. 70.)*

(Supreme Court of Arkansas.)

1. INSURANCE—FIRE INSURANCE—VALIDITY OF ORAL CONTRACT.

In the absence of any statutory prohibition, a parol contract of insurance is valid.

(For other cases, see Insurance, Cent. Dig. §§ 203-205, 207, 208; Dec. Dig. § 131[1].)

2. INSURANCE—AGENTS—SCOPE AND EXTENT OF AGENCY.

Where the agent of a fire insurance company authorized to issue policies and to make renewals was not required to receive the premium in advance as a condition precedent to making parol contracts to renew the policy, but had authority to make renewal on credit, he was authorized to make a preliminary contract binding upon the company, to be consummated by filling out and delivering the policy pursuant thereto.

(For other cases, see Insurance, Cent. Dig. § 206; Dec. Dig. § 131[2].)

4. INSURANCE—RENEWAL OF POLICY—EFFECT ON CONTRACT.

The terms of a fire policy are neither enlarged, restricted, nor changed by a renewal, but the rights of both parties, no matter how often a policy of insurance may have been renewed, are bound by the provisions of the policy as originally issued.

(For other cases, see Insurance, Cent. Dig. §§ 276, 278-283, 287-291; Dec. Dig. § 145[1].)

* Decision rendered, June 19, 1916. 187 S. W. Rep. 657.

5. INSURANCE—FIRE INSURANCE—ACTIONS—COSTS AND ATTORNEY'S FEES.

Under Acts 1905, p. 307, providing that where an insurance company, liable for a loss, fails to pay within the time specified in the policy, a reasonable attorney's fee, together with 12 per cent damages upon the amount of the loss, shall be taxed as a part of the costs in an action upon an alleged oral contract to renew a policy of fire insurance, which had not been consummated by delivering a policy to plaintiff, the allowance of an attorney's fee and the penalty provided by the statute was error.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

Appeal from Circuit Court, Cleburne County; J. I. Worthington, Judge.

Action by W. J. Short against the Aetna Insurance Company and others. Judgment for plaintiff, and defendants appeal. Affirmed in part. Reversed and dismissed in part.

Cockrill & Armistead, of Little Rock, for Appellants.

M. E. Vinson, of Heber Springs, and Gus Seawel, of Yellville, for Appellee.



SMITH ET AL. vs. WESTERN ASSUR. CO. OF CANADA.

(No. 7294.)*

(Court of Appeals of Georgia.)

1. INSURANCE—FIRE INSURANCE—FORFEITURE—WAIVERS.

Forfeiture of insurance under a fire-insurance policy as a result of failure of the insured to furnish proof of loss according to the terms of the contract, is not waived by the insurance company by having the loss investigated by an adjuster a few days after the fire, when the policy provides for such investigation, and that the insurance company "shall not to be held to have waived any provision or condition of this policy or any forfeiture thereof by any requirement, act, or proceeding on its part relating to the appraisal or to any examination herein provided for." See Phenix Insurance Co. vs. Searles, 100 Ga. 98, 27 S. E. 780; Everett-Ridley-Ragan Co. vs. Traders' Ins. Co., 121 Ga. 230, 48 S. E. 918, 104 Am. St. Rep. 99.

(For other cases, See Insurance, Cent. Dig. §§ 1406, 1407, 1409; Dec. Dig. § 561.)

Error from City Court of Floyd County; W. J. Nunnally, Judge.

Action by J. M. Smith and others against the Western Assurance Company of Canada. There was a judgment of nonsuit, and plaintiffs bring error. Affirmed.

C. I. Carey and M. B. Eubanks, both of Rome, for Plaintiffs in Error.
Smith, Hammond & Smith, of Atlanta, for Defendant in Error.

* Decision rendered, July 19, 1916. 89 S. E. Rep. 533. Syllabus by the Court.

GLOBE & RUTGERS FIRE INS. CO. vs. INDIANA REDUCTION CO. (No. 9059.)*

(Appellate Court of Indiana, Division No. 1.)

3. INSURANCE—WAIVER—KNOWLEDGE OF GENERAL AGENT.

An insurance company is charged with its general agent's knowledge of assured's use of gasoline contrary to a provision of the policy.

(For other cases, see Insurance, Cent. Dig. §§ 968, 975-997; Dec. Dig. § 378[1].)

4. INSURANCE — WAIVER — KNOWLEDGE OF INSURANCE BROKER.

An insurance company is charged with the knowledge of an insurance broker, obtained while acting within the scope of his authority as agent for the company, as to assured's use of gasoline contrary to a provision of the policy.

(For other cases, see Insurance, Cent. Dig. 968, 975-997; Dec. Dig. § 378[1].)

5. INSURANCE — ACTIONS — SUFFICIENCY OF EVIDENCE — ACTUAL KNOWLEDGE OF INSURANCE COMPANY.

Evidence held to sustain a finding that an insurance company, through its general agent and insurance broker, had actual knowledge of assured's use of gasoline contrary to a provision of the policy.

(For other cases, see Insurance, Cent. Dig. § 1725; Dec. Dig. § 665[8].)

6. INSURANCE — WAIVER — ISSUANCE OF POLICY—EXISTING BREACH.

Where an insurance company issues a policy with actual or constructive knowledge that the assured is using an article prohibited by its terms, the issuance waives the prohibition.

(For other cases, see Insurance, Cent. Dig. § 1028; Dec. Dig. § 389[1].)

7. INSURANCE—WAIVER—ISSUANCE OF RIDER.

An insurance policy rider, which redistributed the insurance and included new property, held to constitute a new insurance contract, within the rule that the issuance of the policy with knowledge of assured's use of a substance prohibited by its terms waives such prohibition.

(For other cases, see Insurance, Cent. Dig. §§ 1028, 1031; Dec. Dig. § 389[8].)

8. INSURANCE—ACTIONS—SUFFICIENCY OF EVIDENCE—CONSTRUCTIVE KNOWLEDGE OF INSURER.

Evidence held to sustain a finding that an insurance company had constructive notice of assured's use of gasoline, especially where a rider mentioned the property as a degreasing plant and the testimony indicated that gasoline was used in such plants.

(For other cases, see Insurance, Cent. Dig. § 1725; Dec. Dig. § 665[8].)

9. INSURANCE — WAIVER — KNOWLEDGE — WHAT CONSTITUTES.

An insurance company is presumed to be familiar with the substances used in assured's business.

(For other cases, see Insurance, Cent. Dig. § 1658; Dec. Dig. § 646[5].)

* Decision rendered, June 27, 1916. 113 N. E. Rep. 425.

Appeal from Circuit Court, Marion County; Charles Remster, Judge.
 Action by the Indiana Reduction Company against the Globe & Rutgers Fire Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

James Bingham and Elam, Fesler & Elam, all of Indianapolis, for Appellant.
 Monks, Robbins, Starr & Goodrich, of Indianapolis, for Appellee.

E. H. EMERY & CO. vs. AMERICAN INS. CO. OF NEWARK,
 N. J. (No. 30663.)*
 (Supreme Court of Iowa.)

3. INSURANCE—CONSTRUCTION OF POLICY “EJUSDEM GENERIS”—“OTHER MERCHANDISE.”

Under the doctrine of *eiusdem generis*, that general words used in a contract after specific terms are limited to things of like kind and nature with those specified, in a policy of fire insurance on “stock of fruit and vegetables, * * * and all other merchandise,” “all other merchandise” had reference to the same kind of merchandise, and did not cover a loss of ice cream.

(For other cases, see *Insurance*, Cent. Dig. § 346; Dec. Dig. § 163[5].)

4. INSURANCE—CONSTRUCTION OF POLICY—CONSTRUCTION OF CONTRACT AS A WHOLE—“OTHER FURNITURE AND FIXTURES.”

In a policy of fire insurance on “furniture and fixtures to include shelving, partitions, furniture, iron safes, stationery, gas and electric light fixtures, stoves, scales, tools, and all other furniture and fixtures,” the term “furniture and fixtures” would not include ice cream freezers and testers forming a distinctive department installed subsequent to the policy, although considered as fixtures, since the rule of *eiusdem generis* must yield to the rule that a contract must be construed as a whole.

(For other cases, see *Insurance*, Cent. Dig. § 346; Dec. Dig. § 163[5].)

5. INSURANCE—CONSTRUCTION OF POLICY—CONSTRUCTION OF CONTRACT AS A WHOLE—“OTHER APPARATUS AND MERCHANDISE.”

In a policy of fire insurance on ice cream machines and carriers, the subsequent general words, “all other apparatus and merchandise herein not mentioned used in the manufacture of ice cream,” not being limited to the previous specific terms, dealing with the same subject, cover ice cream freezers and testers.

(For other cases, see *Insurance*, Cent. Dig. § 346; Dec. Dig. § 163[5].)

6. INSURANCE—CONSTRUCTION OF POLICY—CONCURRENT INSURANCE.

Policies of fire insurance upon a general stock of fruits, vegetables, furniture, and fixtures, do not cover a subsequently acquired ice cream

* Decision rendered, June 29, 1916. 158 N. W. Rep. 748.

department, being property concededly not of a like kind or description, and are not concurrent insurance, and the doctrine of shifting risk, that a policy on constantly changing stock covers that which is in hand at the time of the loss, does not apply.

(For other cases, see Insurance, Cent. Dig. § 346; Dec. Dig. § 163[5].)

Appeal from District Court, Wapello County; Francis M. Hunter, Judge.

McNett & McNett, of Ottumwa, for Appellant.
Chester W. Whitmore, of Ottumwa, for Appellee.

FISK vs. FIRE ASS'N OF PHILADELPHIA. (No. 229.)*

(Supreme Court of Michigan.)

1. INSURANCE—PROOFS OF LOSS—WAIVER—POWERS OF ADJUSTER.

A fire insurance adjuster is authorized to waive presentation of proofs of loss by denying the company's liability, especially where the company later advised plaintiff that the entire matter had been referred to the adjuster.

(For other cases, see Insurance, Cent. Dig. §§ 1375, 1376; Dec. Dig. § 556[2].)

2. INSURANCE — ACTIONS — SUFFICIENCY OF EVIDENCE — WAIVER—DENIAL OF LIABILITY.

Evidence held to sustain a verdict that a fire insurance company's adjuster denied liability and thereby waived presentation of proofs of loss.
(For other cases, see Insurance, Cent. Dig. § 1725; Dec. Dig. § 665[8].)

Error to Circuit Court, Sanilac County; Watson Beach, Judge.
Action by Charles Fisk against the Fire Association of Philadelphia. From judgment for plaintiff, defendant brings error. Affirmed.

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, Brooke, and Person, J.J.

Phillips & Jenks, of Port Huron, for Appellant.

Fred A. Farr, of Sandusky (C. F. Gates, of Sandusky, of counsel), for Appellee.

* Decision rendered, July 21, 1916. 158 N. W. Rep. 947.

POPA vs. NORTHERN INS. CO. OF NEW YORK. (No. 253.)*

(Supreme Court of Michigan.)

1. INSURANCE—PROOFS OF LOSS—WAIVER—POWER OF ADJUSTER.

A fire insurance adjuster is presumably authorized to waive presentation of the proofs of loss by denying the company's liability.

(For other cases, see Insurance, Cent. Dig. §§ 1375, 1376; Dec. Dig. 556[2].)

2. INSURANCE—PROOFS OF LOSS—WAIVER—DENIAL OF LIABILITY—FIRE INSURANCE.

Rejection of a fire insurance claim waives presentation of the proofs of loss.

(For other cases, see Insurance, Cent. Dig. §§ 1391, 1392; Dec. Dig. § 559[1].)

3. INSURANCE—ACTIONS—WAIVER OF LIMITATION—DENIAL OF LIABILITY.

A fire insurance policy provision, that suit could not be brought within sixty days after presentation of the proofs of loss, is waived by the company's denial of liability.

(For other cases, see Insurance, Cent. Dig. § 1551; Dec. Dig. § 623[4].)

4. INSURANCE—ACTIONS—ADMISSIBILITY OF EVIDENCE—VALUATION OF PROPERTY.

Testimony as to the price paid for insured's household goods about one year before the fire, the amount of wear they received, and their condition at the date of the fire is competent evidence of their value when burned.

(For other cases, see Insurance, Cent. Dig. § 1695; Dec. Dig. § 660.)

Error to Circuit Court, Wayne County; Kelly S. Searl, Judge.

Action by Andrew Popa against the Northern Insurance Company of New York, a corporation. Judgment for plaintiff, and defendant brings error. Affirmed.

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, Brooke, and Person, JJ.

Frederick J. Ward, of Detroit, for Appellant.

James I. Ellmann, of Detroit (Walter Phillips, of Detroit, on the brief), for Appellee.

* Decision rendered, July 21, 1916. 158 N. W. Rep. 945.

**TERMINAL ICE & POWER CO. vs. AMERICAN FIRE INS.
CO. (No. 11664.)***

(Kansas City Court of Appeals. Missouri.)

4. INSURANCE—AVOIDANCE—TITLE—“FEE SIMPLE.”

A policy, not mentioning incumbrances, but providing for fee-simple ownership, is not breached by existence of mortgage liens.

(For other cases, see Insurance, Cent. Dig. §§ 613, 614; Dec. Dig. § 282[6].)

5. INSURANCE—AVOIDANCE—TITLE “UNCONDITIONAL AND SOLE OWNERSHIP.”

Where there is no mention of incumbrances, a policy provision of “unconditional and sole ownership” of a building is not breached by existence of incumbrances.

(For other cases, see Insurance, Cent. Dig. §§ 613, 614; Dec. Dig. § 282[6].)

(For other definitions, see Words and Phrases, First and Second Series, Unconditional and Sole Ownership.)

6. INSURANCE—AVOIDANCE—“CHANGE IN POSSESSION.”

A tenant's going into possession of premises insured by his landlord does not breach a policy provision against “change of possession,” the tenant's possession being that of the landlord.

(For other cases, see Insurance, Cent. Dig. § 760; Dec. Dig. § 322.)

(For other definitions, see Words and Phrases, First and Second Series, Change.)

7. INSURANCE—AVOIDANCE—“CHANGE IN INTEREST OR TITLE.”

The giving of a mere option, not exercised, on insured property, does not breach a policy provision against “change in interest or title,” since the change of interest referred to in the policy means some change which would cause the loss by fire to fall on the buyer and thus change the risk.

(For other cases, see Insurance, Cent. Dig. § 795; Dec. Dig. § 328[2].)

(For other definitions, see Words and Phrases, First and Second Series, Change.)

8. INSURANCE—AVOIDANCE—FORECLOSURE PROCEEDINGS.

Foreclosure by insured himself of a mortgage, he has bought in on insured property, in order to perfect title, does not avoid a policy under a provision against “foreclosure proceedings,” since forfeitures of a policy are not favored and insured, after loss, cannot avail himself of a policy forfeiture provision which has not been substantially violated to the enlargement of his risk.

(For other cases, see Insurance, Cent. Dig. §§ 815-817; Dec. Dig. § 328[14.])

* Decision rendered, May 1, 1916. Rehearing denied, July 3, 1916. 187 S. W. Rep. 564.

9. INSURANCE—AVOIDANCE—INSURED'S TITLE.

A policy is not avoided by lack of title of insured, where the sheriff's deed of the property to another is not effective and is a mere cloud on insured's title.

(For other cases, see Insurance, Cent. Dig. §§ 613, 614; Dec. Dig. § 282[6].)

Appeal from Circuit Court, Jackson County; A. C. Southern, Judge. Action by the Terminal Ice & Power Company against the American Fire Insurance Company. From a judgment for defendant, plaintiff appeals. Reversed and remanded.

Lathrop, Morrow, Fox & Moore and Boyle & Howell, all of Kansas City, for Appellant.

Fyke & Snider, of Kansas City, for Respondent.

**YOUNG v. PENNSYLVANIA FIRE INS. CO. (No. 17889.)***

(Supreme Court of Missouri, Division No. 1.)

1. INSURANCE—ACTIONS—DEFENSES—PREMATURE SUIT—PLEADING—SUFFICIENCY.

In an action on a fire insurance policy, the defense of premature suit (suit within sixty days after filing proof of loss) is in the nature of a plea in abatement, not a plea in bar, and to be available must be specifically pleaded; a general denial not being sufficient.

(For other cases, see Insurance, Cent. Dig. §§ 1554, 1609; Dec. Dig. § 640[1].)

2. INSURANCE—FIRE INSURANCE—PROOF OF LOSS—WAIVER.

Where defendant's insurance adjuster admitted liability under fire insurance policy, and after a dispute as to the amount of loss an arbitration followed, no blank proofs of loss being furnished the plaintiff as required by statute, *held*, there was a complete waiver by defendant of proof of loss.

(For other cases, see Insurance, Cent. Dig. § 1387; Dec. Dig. § 558[4].)

3. INSURANCE—DEFENSES—PLEADING—WAIVER OF PROOF OF LOSS.

Where defendant fire insurance company pleaded an arbitration, it thereby admitted a waiver of proof of loss.

(For other cases, see Insurance, Cent. Dig. § 1620; Dec. Dig. § 640[4].)

4. INSURANCE—FIRE INSURANCE—PROOFS OF LOSS—WAIVER.

In an action on a fire insurance policy, the defense of premature suit (suit within sixty days after filing proof of loss) is not available where proofs of loss were waived by submitting to arbitration, and such arbitration was pleaded as a defense.

(For other cases, see Insurance, Cent. Dig. § 1551; Dec. Dig. § 623[1].)

* Decision rendered, Mar. 30, 1916. Motions for rehearing and to transfer to Court in Banc denied, June 2, 1916. Motion in Banc to require Division I to transfer to Banc denied, July 3, 1916. 187 S. W. Rep. 856.

5. INSURANCE—FIRE INSURANCE—PROOFS OF LOSS—WAIVER.

The waiver of proofs of loss under fire insurance policy has the same effect as the filing of proofs of loss, and a suit commenced more than sixty days after such waiver is not premature, although proofs of loss were made as a matter of precaution less than sixty days before suit.

(For other cases, see Insurance, Cent. Dig. §§ 1542, 1543; Dec. Dig. § 621.)

6. INSURANCE—ACTIONS—CONDITIONS PRECEDENT—VALIDITY OF CONTRACT PROVISIONS COMPELLING ARBITRATION.

Under Rev. St. 1909, § 868, provisions in contracts including insurance policies which enforce arbitration or settlement are unenforceable, and compliance therewith is not a condition precedent to a suit on such a contract.

(For other cases, see Insurance, Cent. Dig. §§ 1522-1528; Dec. Dig. § 612[3].)

7. INSURANCE—ACTIONS ON POLICIES—STATUTE—RETROACTIVE OPERATION.

The provisions of Rev. St. 1909, § 868 (Laws 1909, p. 347), providing that contracts containing agreements to arbitrate shall not preclude suit without submitting to arbitration held not retroactive, so that an insurance policy executed in 1907 would not be affected thereby.

(For other cases, see Insurance, Dec. Dig. § 610.)

8. INSURANCE—APPRAISEMENT—EFFECT AS A BAR.

An appraisement under a fire insurance policy does not discharge the cause of action on such policy, although binding as to the amount fixed by such appraisement if not fraudulently procured.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432, 1433; Dec. Dig. § 574[5].)

9. INSURANCE—APPRAISEMENT—FRAUDULENT APPRAISEMENT—“SETTLEMENT.”

The word “settlement” has at times a broader significance than of payment and satisfaction, and often means an agreement by which disputed matters are adjusted, and, as used in Rev. St. 1909, § 1812, providing that fraud may be pleaded by way of reply to avoid a fraudulent settlement, permits the insured to set up in his reply that an appraisement of his loss was fraudulent and invalid.

(For other cases, see Insurance, Cent. Dig. §§ 1554, 1626, 1628, 1629; Dec. Dig. § 641[1].)

(For other definitions, see Words and Phrases, First and Second Series, Settlement.)

12. INSURANCE—APPRAISEMENT—FRAUD—EVIDENCE—SUFFICIENCY.

Evidence held sufficient to warrant a finding that appraisement of loss under a fire insurance policy was fraudulent

(For other cases, see Insurance, Cent. Dig. §§ 1723, 1724, 1726, 1727; Dec. Dig. § 665[7].)

14. INSURANCE—VEXATIOUS REFUSAL TO PAY LOSS—ALLOWANCE OF ATTORNEY FEES—EVIDENCE—SUFFICIENCY.

Evidence that insurance company threatened to keep case in court for five years if plaintiff did not accept fraudulent appraisement, together

with other evidence, *held* sufficient to sustain an award of attorney fees under the statute for vexatiously refusing to pay fire insurance. (For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

Appeal from Circuit Court, Audrain County; James D. Barnett, Judge. Action by Lulu Young against the Pennsylvania Fire Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Ryan & Thompson, of St. Louis, for Appellant.
Frank H. Haskins and Fauntleroy, Cullen & Hay, all of St. Louis, for Respondent.



INSURANCE CO. OF NORTH AMERICA *vs.* COCHRAN
ET AL. (No. 6307.)*

(Supreme Court of Oklahoma.)

1. INSURANCE—PROOFS OF LOSS—SUFFICIENCY.

Substantial compliance with the requirements of proof of loss is sufficient. *Held*, in this cause, that the proof of loss under the circumstances was a substantial compliance with the requirements of the policy.

(For other cases, see Insurance, Cent. Dig. § 1338; Dec. Dig. § 540.)

2. INSURANCE—PROOFS OF LOSS—WAIVER.

Where the petition alleges the making of proper proof of loss and the evidence discloses that proof of loss, though defective, was accepted and retained by the company and no complaint made of the defects or notice given the insured, *held* such defects waived, and further proof unnecessary.

(For other cases, see Insurance, Cent. Dig. § 1393; Dec. Dig. § 560[1].)

Commissioners' Opinion, Division No. 5. Error from District Court, Rogers County; Frank Ertell, Special Judge.

Action by William Taylor and A. G. Cochran, trustee in bankruptcy, against the Insurance Company of North America. Judgment for plaintiffs, and defendant brings error. Affirmed.

Burwell, Crockett & Johnson, of Oklahoma City, for Plaintiff in Error.
Dennis H. Wilson, of Vinita, for Defendants in Error.

* Decision rendered, June 20, 1916. 159 Pac. Rep. 247. Syllabus by the Court.

**PHœNIX INS. CO. OF HARTFORD, CONN., vs. HALL, ET AL.
(No. 7362.)***

(Supreme Court of Oklahoma.)

**INSURANCE — FORM OF POLICY — RIDERS — STATUTE —
“SEPARATE” SLIPS.**

A separate sheet of paper, having printed thereon certain stipulations including the usual iron safe and book warranty clauses, and also containing at the head of said sheet of paper a description of the property insured was pasted on that blank portion of a standard insurance policy form left for the insertion of the description of the property, so that the part containing the description filled up the blank and the remainder of the sheet, containing said book warranty, etc., clauses, was left loose, except where attached at the head thereof. *Held* to be a substantial compliance with subdivisions 4 and 6 of section 3481, Rev. Laws, 1910.

(For other cases, see Insurance, Cent. Dig. §§ 203, 211; Dec. Dig. § 133[1].)

Commissioners' Opinion, Division No. 2. Appeal from District Court, Texas County; W. C. Crow, Judge.

Action by Emil Hall and others against the Phoenix Insurance Company of Hartford, Conn., to recover on certain insurance policies. There was judgment for the plaintiffs, and defendant appeals. Reversed.

Scothorn, Caldwell & McRill, of Oklahoma City, for Plaintiff in Error.
John L. Gleason, of Guymon, for Defendants in Error.

* Decision rendered, June 13, 1916. Rehearing denied, July 25, 1916. 158 Pac. Rep. 903. Syllabus by the Court.



**QUEEN INS. CO. OF AMERICA vs. DALRYMPLE ET AL.
(No. 7363.)***

(Supreme Court of Oklahoma.)

1. INSURANCE—AVOIDANCE OF POLICY—BREACH OF WARRANTY—BOOK WARRANTY CLAUSE.

The book warranty clause of the standard form of fire insurance policy in use in Oklahoma is complied with by the assured if the set of books kept by them are sufficient to enable a man of ordinary intelligence to ascertain from them, with reasonable certainty, the amount and value of the goods destroyed.

(For other cases, see Insurance, Cent. Dig. § 853; Dec. Dig. § 335[3].)

* Decision rendered, July 11, 1916. 158 Pac. Rep. 1154. Syllabus by the Court.

2. INSURANCE—ACTIONS ON POLICIES—EVIDENCE.

Facts examined, and *held* to support the finding of the trial court that there has been a reasonable compliance with the book warranty clause of the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1711-1716; Dec. Dig. § 665[3].)

Commissioners' Opinion, Division No. 2. Appeal from District Court, Oklahoma County; W. R. Taylor, Judge.

Action by J. C. Dalrymple and another, as partners under the style and name of J. C. Dalrymple & Co., against the Queen Insurance Company of America. From a judgment for plaintiffs, defendant appeals. Affirmed.

Scothorn, Caldwell & McRill, of Oklahoma City, for Plaintiff in Error.

George H. Giddings and J. T. Dorch, both of Oklahoma City, for Defendants in Error.



CARLTON LUMBER CO. vs. LUMBER INS. CO. OF NEW YORK.*

(Supreme Court of Oregon.)

1. INSURANCE—FIRE INSURANCE—"BLANKET POLICY."

A blanket policy of fire insurance covers to its full amount every item of property described in it, and, if the loss of any portion of the property exhausts the full amount of the policy, the whole insurance must be paid; hence the existence of an average clause in a blanket policy involves a contradiction of terms (citing Words and Phrases).

(For other cases, see Insurance, Cent. Dig. § 1269; Dec. Dig. § 494.)

3. INSURANCE—REFORMATION OF POLICIES—CARELESSNESS OF INSURED IN EXAMINING POLICIES.

The carelessness of the insured in not examining insurance policies, *held* not of such character as would prevent the reformation of the policy by striking therefrom an average clause, thus making the policy a blanket policy.

(For other cases, see Insurance, Cent. Dig. § 272; Dec. Dig. § 143[8].)

Department 1. Appeal from Circuit Court, Multnomah County; W. N. Gatens, Judge.

Suit by the Carlton Lumber Company, a corporation, against the Lumber Insurance Company of New York, a corporation, to reform insurance policies. Judgment for plaintiff, and defendant appeals. Affirmed.

J. C. Veazie, of Portland (Veazie, McCourt & Veazie, of Portland, on the brief), for Appellant.

James G. Wilson, of Portland, for Respondent.

* Decision rendered, July 25, 1916. 158 Pac. Rep. 807.

**SMITH vs. SECURITY MUT. FIRE INS. CO. OF CHATFIELD,
MINN. (No. 3924.)***

(Supreme Court of South Dakota.)

INSURANCE—FIRE INSURANCE—CHANGE IN TITLE.

Where the owner of insured property assigned all his property for the benefit of creditors, the assignee taking immediate possession, the policy of fire insurance, which provided that it should be void if any change, other than by death, took place in the interest, title, or possession of the subject of insurance, became void and unenforceable by the insured's trustee in bankruptcy.

(For other cases, see Insurance, Cent. Dig. § 809; Dec. Dig. § 328[10].)

Appeal from Circuit Court, Minnehaha County; Joseph W. Jones, Judge.

Action by Hugh Smith, trustee in bankruptcy, against the Security Mutual Fire Insurance Company of Chatfield, Minn., a corporation. From a judgment for plaintiff, defendant appeals. Judgment reversed.

Sam H Wright, of Sioux Falls, for Appellant.
Kirby & Kirby, of Sioux Falls, for Respondent.

* Decision rendered, July 29, 1916. 158 N. W. Rep. 991.



**FIREMAN'S INS. CO. vs. JESSE FRENCH PIANO &
ORGAN CO. ET AL. (No. 998.)***

(Court of Civil Appeals of Texas. Amarillo.)

3. INSURANCE—QUESTION FOR COURT—CONSTRUCTION OF CONTRACT.

The construction of a written provision of a policy as to the extent of the insurer's liability was a question for the court, and not for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1734, 1755; Dec. Dig. § 668[3].)

5. INSURANCE—AMOUNT OF RISK—"COINSURER" STATUTE.

Under Vernon's Sayles' Ann. Civ. St. 1914, art. 4893, providing that no company may issue any policy covering property in the state containing any provision that the insured shall be liable as a coinsurer for any part of the loss or damage to the property by fire, a provision in a fire insurance policy, covering a piano valued therein at \$500, on which amount the company collected a premium, that in the event of loss or damage the company should not be liable for more than three-fourths of its cash value immediately preceding any loss or damage, and that in the event of other insurance it should be liable only for its proportion of three-fourths of such cash value at the time of the

* Decision rendered, May 31, 1916. Rehearing denied, June 28, 1916. 187 S. W. Rep. 691.

fire, in the absence of showing of concurrent insurance, was void, though there can be no "coinsurer" where the insured does not bear a proportion of the risk.

(For other cases, see Insurance, Cent. Dig. §§ 1270-1272; Dec. Dig. § 495[1].

(For other definitions, see Words and Phrases, Coinsurer.)

Error from Dallas County Court, at Law; W. F. Whitehurst, Judge. Suit by the Jesse French Piano & Organ Company and another against the Fireman's Insurance Company. Judgment for plaintiffs, and defendant brings error. Affirmed.

Senter & Synnott, of Dallas, for Plaintiff in Error.
Short & Feild, of Dallas, for Defendants in Error.

CAMDEN FIRE INS. ASS'N *vs.* BAIRD ET AL. (No. 7556.)*

(Court of Civil Appeals of Texas. Dallas.)

3. INSURANCE—LIABILITY—CLAIMS.

Where the trustee, to whom an insurance policy was payable as his interest might appear, in suit on the policy by the owner, answered, disclaiming interest, the owner's right to recover the full amount due under the policy, was established, and not cut off by his disclaimer.

(For other cases, see Insurance, Cent. Dig. §§ 1448-1451, 1453, 1454, 1485; Dec. Dig. § 582.)

Appeal from Dallas County Court; T. A. Work, Judge.

Action by Emma C. Baird against the Camden Fire Insurance Association and another. Judgment on directed verdict for plaintiff, and for C. H. Verschoyle, defendant, for costs, and defendant Insurance Company appeals. Affirmed.

Senter & Synnott, of Dallas, for Appellant.
Short & Feild, of Dallas, for Appellees.

* Decision rendered, May 20, 1916. Rehearing denied, July 1, 1916. 187
S. W. Rep. 699.

ST. PAUL FIRE & MARINE INS. CO. *vs.* LASTER.

(No. 7593.)*

(Court of Civil Appeals of Texas. Dallas.)

1. INSURANCE—ACTION—COMPLAINT.

A complaint in an action on fire insurance policy need not allege that the fire did not result from causes for which insurer was not liable.

(For other cases, see Insurance, Cent. Dig. §§ 1554, 1593, 1598; Dec. Dig. 639.)

* Decision rendered, June 10, 1916. Rehearing denied, July 1, 1916. 187
S. W. Rep. 969.

3. INSURANCE—PROOF OF LOSS—STATUTORY PROVISION.

Under Vernon's Sayles' Ann. Civ. St. 1914, art. 4874, providing that, in case of a total loss by fire, the claim shall be considered a liquidated demand against the company for the full amount of the policy, where the insured premises are a total loss, no showing or proof of the amount, etc., of the loss is necessary, for, since the policy sum is by the statute converted into a liquidated demand, suit may be commenced on it as on any other demand where the amount due has been ascertained.

(For other cases, see Insurance, Cent. Dig. § 1665; Dec. Dig. § 646[8].)

Error from District Court, Freestone County; A. M. Blackman, Judge.

Action by G. W. Lester against the St. Paul Fire & Marine Insurance Company. Judgment for plaintiff, and defendant brings error. Affirmed.

Elliott Cage, of Houston, for Plaintiff in Error.

**GLENS FALLS INS. CO. vs. WALKER. (No. 8387.)***

(Court of Civil Appeals of Texas. Ft. Worth.)

1. INSURANCE—ACTIONS—SUFFICIENCY OF EVIDENCE—DELIVERY OF POLICY.

Evidence held to sustain a verdict that a fire insurance policy was delivered to assured.

(For other cases, see Insurance, Cent. Dig. § 1709; Dec. Dig. § 665[2].)

2. INSURANCE—ACTIONS—SUFFICIENCY OF EVIDENCE—CANCELLATION OF POLICY.

Evidence held to sustain a verdict that a fire insurance policy was not canceled by mutual consent.

(For other cases, see Insurance, Cent. Dig. § 507; Dec. Dig. § 235.)

4. INSURANCE—ACTIONS—EVIDENCE—ADMISSIBILITY—CANCELLATION OF POLICY.

Where the defendant fire insurance company claimed that a policy had been canceled by mutual consent in a conversation between its agent and assured, the assured's explanation that he understood the policy was void only during certain foreclosure proceedings is admissible, where the conversation was somewhat ambiguous.

(For other cases, see Insurance, Cent. Dig. § 1673; Dec. Dig. § 651[4].)

Appeal from District Court, Tarrant County; R. B. Young, Judge.
Action by Herbert G. Walker against the Glens Falls Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.
See, also, 166 S. W. 122.

Crane & Crane, of Dallas, for Appellant.
Charles Kassel, of Fort Worth, for Appellee.

* Decision rendered, June 3, 1916. Rehearing denied, July 1, 1916. 187 S. W. Rep. 1036.



NATIONAL UNION FIRE INS. CO. OF PITTSBURGH *vs.*
DICKINSON ET AL. (No. 13311.)*

(Supreme Court of Washington.)

1. INSURANCE—DUTY OF AGENTS—ACTIONS FOR NEGLIGENCE.

Insurance agents, sued by their company for loss from not cancelling policies as directed by it, cannot deny that it was their duty to do so, they having undertaken to do it, when, had they refused, it might seasonably have been done by the company.

(For other cases, see Insurance, Cent. Dig. § 108; Dec. Dig. § 83[2].)

3. INSURANCE—AGENTS—FAILURE TO CANCEL POLICIES—EVIDENCE.

Evidence in action by an insurance company against its agents held to authorize a finding that they had not canceled policies as directed by it, or even used ordinary care to do so.

(For other cases, see Insurance, Cent. Dig. § 108; Dec. Dig. § 83[2].)

Department 2. Appeal from Superior Court, King County; Kenneth Mackintosh, Judge.

Action by the National Union Fire Insurance Company of Pittsburgh against C. E. Dickinson and another, partners as C. E. Dickinson & Co. Judgment for plaintiff, and defendants appeal. Affirmed.

William Wray, of Seattle, for Appellants.
Jas. B. Murphy, of Seattle, for Respondent.

* Decision rendered, July 17, 1916. 159 Pac. Rep. 125.

ACCIDENT AND HEALTH.**SUPREME COURT OF CALIFORNIA.****POSTLER****vs.****TRAVELERS' INS. CO. (S. F. 6947.)*****1. INSURANCE—ACTIONS—BURDEN OF PROOF—SUICIDE.**

The insurer has the burden of proving that the assured committed suicide. (For other cases, see Insurance, Cent. Dig. § 1663; Dec. Dig. § 646[7].)

2. INSURANCE — ACTIONS — SUFFICIENCY OF EVIDENCE — SUICIDE.

Evidence *held* to sustain a verdict that an assured, who was killed by a revolver shot, did not commit suicide.

(For other cases, see Insurance, Cent. Dig. § 1720; Dec. Dig. § 665[6].)

3. INSURANCE—ACTIONS—BURDEN OF PROOF—CAUSE OF DEATH.

Under a policy insuring against bodily injuries from accidental means, the plaintiff has the burden of proving that assured's death was accidental. (For other cases, see Insurance, Cent. Dig. §§ 1659-1662, 1664; Dec. Dig. § 646[6].)

4. INSURANCE—CAUSE OF LOSS—LIFE INSURANCE.

Where assured armed himself and went to a gambling house with the stated purpose of recovering money previously lost there, and was fatally shot during the attempt, *held* that his death was not accidental, but was the natural result of his own acts.

(For other cases, see Insurance, Cent. Dig. §§ 1166-1169; Dec. Dig. § 455.)

5. INSURANCE — ACTIONS — INSTRUCTION—CONSTRUCTION OF POLICY.

An instruction, stating the rule for interpreting exceptions in an insurance policy, is improper, for such interpretation is for the court, not for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1734, 1755; Dec. Dig. § 668[3].)

7. INSURANCE—ACTIONS—BURDEN OF PROOF—CAUSE OF DEATH.

In an action on a policy insuring against accidental death, the burden of proving, upon the entire evidence, that death was accidental rests upon the plaintiff, despite the presumption that a violent death was accidental.

(For other cases, see Insurance, Cent. Dig. § 1663; Dec. Dig. § 646[7].)

* Decision rendered, July 1, 1916. Rehearing denied, July 31, 1916. 158 Pac. Rep. 1022.

Department 1. Appeal from Superior Court, City and County of San Francisco; Adolphus E. Graupner, Judge.

Action by Anna Postler against the Travelers' Insurance Company. From a judgment for plaintiff, and an order denying a new trial, defendant appeals. Reversed and remanded.

Coogan & O'Connor, of San Francisco, for Appellant.
F. J. Castelhun, of San Francisco, for Respondent.

SLOSS, J.

The plaintiff, wife of Gustave Postler, was the beneficiary named in two policies of accident insurance issued by the defendant to said Postler. By each of the policies Postler was insured in the principal sum of \$1,000 "against bodily injuries effected directly and independently of all other causes through external, violent, and accidental means (suicide, whether sane or insane, is not covered)." The complaint alleged that on the 27th day of January, 1911, said Gustave Postler "received a bodily injury through external, violent, and accidental means * * * to wit, by the discharge of a revolver in the hands of one Ed. Kripp, which said injuries caused the immediate death of said Gustave Postler." These allegations are denied by the answer, which also set up as a separate defense that Postler committed suicide. The case was tried before a jury, which returned a verdict in favor of plaintiff for the full amount claimed on both policies. The defendant appeals from the judgment entered upon this verdict, and from an order thereafter made denying its motion for a new trial.

There was some conflict in the evidence, but the facts which we are about to state appear in the testimony without substantial dispute. Postler was a painter, living with his wife and son in San Francisco. He had visited the Saratoga Club, a gambling resort located on Mason street in the said city, and had apparently lost money in gambling there. On January 27, 1911, Postler left his home accompanied by his son, a boy of about sixteen years. They were riding in a buggy. After going to various places, among others a hardware store, where Postler bought a revolver and some cartridges, he, with the boy, drove to the location of the Saratoga Club on Mason street, arriving there about noon. During the morning Postler had told his son that he was going to get back the money he had lost. Leaving the boy in the buggy, Postler went up in the elevator to the rooms of the Saratoga Club. There he found four or five men, among whom was one in charge of the place. After a few minutes, he drew his revolver and ordered the men present to hold up their hands. Two or three of them, including Kripp, ran out of the room, and Kripp found his way to the sidewalk, where he encountered a police sergeant, from whom he obtained a pistol. Learning from Postler's son that the man upstairs was the boy's father, Kripp asked the boy to go up with him to induce the father to leave peaceably.

Kripp and young Postler then went up in the elevator. In the meanwhile, Postler had demanded of the men whom he was holding under cover of his revolver the sum of \$1,000, saying that he had come up there to get the money and if he did not get it he was going to kill somebody and kill himself. Goodrich, the man in charge, told him he could have the money and produced it. He counted out \$1,000, which he placed on a table. Postler took the money and put most of it in his pocket, some part of it dropping to the floor in the process. At this stage of the affair, Kripp and the boy appeared. The boy urged his father to give up the money, but the father put him aside. Postler then observed Kripp standing at the door of the room and ordered him to come in. Kripp turned and ran, followed by Postler. The two were thus brought into a room adjoining the one in which the boy and the other men stood. There was an exchange of shots between Kripp and Postler, and Postler fell, mortally wounded. The evidence does not make it clear whether Postler or Kripp fired the first shot.

[1, 2] There was some evidence which, so the defendant claimed, tended to show that Postler had himself fired the shot which ended his life. On the issue of suicide the burden of proof rested upon the defendant (*Dennis vs. Union Mutual Life Ins. Co.*, 84 Cal. 570, 24 Pac. 120), and it cannot be questioned that the jury was fully justified in finding that this burden had not been sustained.

[3, 4] But the defendant relied, in addition, upon its denial that the injuries which caused Postler's death had been effected through accidental means. On this issue the burden of proof was upon the plaintiff. "The plaintiff was bound to establish as a part of her case that death resulted from accident. It was not incumbent upon the defendant to negative accident. * * * In order to recover, the plaintiff was bound to allege and prove an injury of a kind covered by the contract, i. e., one effected through external, violent and accidental means." *Price vs. Occidental Life Ins. Co.*, 169 Cal. 800, 802, 147 Pac. 1175; *Jenkin vs. Pacific Mutual L. Ins. Co.*, 131 Cal. 121, 63 Pac. 180; *Rock vs. Travelers' Ins. Co.*, 156 Pac. 1029. The appellant contends, and we think upon good ground, that under any reasonable view of the evidence, the injuries suffered by Postler were not produced by accidental means, but were the natural and probable consequence of his own voluntary acts. In *Western Commercial Travelers' Ass'n vs. Smith*, 85 Fed. 401, 405, 29 C. C. A. 223, 227 (40 L. R. A. 653), the court said that:—

"An effect which is the natural and probable consequence of an act or course of action is not an accident, nor is it produced by accidental means. It is either the result of actual design, or it falls under the maxim that every man must be held to intend the natural and probable consequence of his deeds. On the other-

hand, an effect which is not the natural or probable consequence of the means which produced it. * * *

See, also, 4 Cooley, Briefs on Insurance, p. 356; Fidelity, etc., Co. vs. Stacey's Executors, 143 Fed. 271, 74 C. C. A. 409, 5 L. R. A. (N. S.) 657, 6 Ann. Cas. 955; Price vs. Occidental Ins. Co., *supra*; Bock vs. Travelers' Ins. Co., *supra*; Hutton vs. State Accident Co., 267 Ill. 267; Prudential Casualty Co. vs. Curry, 10 Ala. App. 642, 65 South. 852. In Price vs. Occidental Life Ins. Co., *supra*, we had occasion to deal with a situation somewhat similar to the one before us. The insured had been killed by the discharge of a revolver held in the hands of another person. It was held that "if it should appear that the killing had been the result of an encounter with deadly weapons, and that the deceased had himself invited and brought on such conflict, the fatal result would not have been accidental so far as he was concerned." The decision of the United States Circuit Court of Appeals in Taliaferro vs. Travelers' Protective Ass'n of America, 80 Fed. 368, 25 C. C. A. 494, was cited with approval. There the court upheld a directed verdict in favor of the insurance company, it appearing that the insured had invited another to a deadly encounter, which had resulted in his killing. Under the undisputed facts, we do not see how the case at bar can be taken out of the principle of those just referred to. Postler, after arming himself and declaring his intention of getting back his money, had gone to the gambling house and had there undertaken to compel the payment of \$1,000 at the point of a pistol. While he was engaged in this effort, an encounter took place between him and one of the men who was in the place when he arrived. In the course of this encounter he was killed.

A man who attempts to obtain money from others by the display of a deadly weapon, aiding such display by threats of killing, must contemplate, as the natural and probable consequence of his actions, that there will be resistance to or interference with the consummation of his plan, and that such resistance or interference will be likely to result in armed conflict and serious injury to one or more of the participants. To all intents and purposes, Postler's position, so far as concerns the probable consequences of his acts, was that of any man who attempts robbery at the point of a firearm. If such a man were killed by his intended victim, it could hardly be claimed that his death was caused by "accidental means," in the sense in which those words are used in policies like the ones before us. We are not suggesting that, from an ethical standpoint, Postler's action was to be judged by the standards which would be applied to the commission of an ordinary robbery. The conditions under which he had lost his money in gambling may have been such as to make him feel, whether rightly or wrongly, that he was justified in resorting to extreme and lawless measures in the effort to recoup his losses. But these considerations do not affect the ultimate question, which

is whether the killing was the natural and probable consequence of his own voluntary acts. Under the authorities above cited, this question must be answered in the affirmative. See, also, *Hutton vs. State Acc. Co., supra*; *Prud. Cas. Co. vs. Curry, supra*.

In reaching the conclusion just indicated, it is immaterial whether the first shot was fired by Postler or by Kripp. Conceding that there is evidence to show that Kripp fired the first shot, it still remains that such shooting was the consequence naturally to be anticipated by a man taking the course which Postler took. The respondent makes the suggestion that the verdict may be upheld on the theory that Postler came to his death through a shot accidentally fired from his own revolver. There is, however, no evidence which would warrant the inference that such was the fact. Every probability is against it, and, besides, plaintiff alleges in her complaint that Postler's death was the result of a gunshot wound inflicted by the discharge of a revolver in the hands of Kripp.

[5-7] Some of the instructions to the jury were inaccurate, but since the case must be remanded for the reasons already stated, these matters need but brief mention. Instruction 4, stating the rule for interpreting exceptions in a policy of insurance, should not have been given to the jury. It stated the rule correctly, but the construction of the contract was a matter of law for the court, and the jury could not have been aided by this instruction in deciding the questions of fact submitted to them. Instruction 9 was misleading. We shall not here quote the instruction, but content ourselves with repeating that upon the issue whether the death was effected by accidental means the burden of proof was on the plaintiff, and she was not entitled to recover unless she satisfied the jury by a preponderance of evidence that the injuries had been so inflicted. On the issue of suicide, on the other hand, the burden of proof was on the defendant and before it could prevail on this ground it was bound to establish by the evidence that Postler's death had been caused by suicide. It is true that where a violent death has occurred the presumption, in the absence of further evidence, is in favor of accidental death and against suicide. *Jenkin vs. Pac. Mut. L. Ins. Co.*, 131 Cal. 121, 63 Pac. 180. This presumption is, however, merely an item in the evidence, and does not impair the force of the rule that on the whole evidence, including the presumptions, the plaintiff must show as a part of her case the fact that injuries were effected by accidental means.

[8] In instruction 9 the court told the jury that the defense set up by the defendant was an affirmative defense to be established by the defendant by a preponderance of testimony. The instruction should have been limited to the defense of suicide. Stated in general terms, it might have been understood to apply to the defense that the injury was not received through accidental means. As so applied it did not state the true rule of law.

There were other instructions which correctly stated the rule with reference to the burden of proof on the various issues. Upon another trial, if the case is to be retried, there should be no difficulty in modifying or eliminating the instructions which we have criticized, so that there may be no conflict in the charge taken as a whole.

The judgment and the order denying a new trial are reversed.
We concur: Shaw, J.; Lawlor, J.

DISTRICT COURT OF APPEAL OF CALIFORNIA.

FIRST DISTRICT.

CLAXTON

vs.

AMERICAN CASUALTY CO. (Civ. 1816.)*

INSURANCE — ACCIDENT POLICY — TIME OF "LOSS" — "DISABILITY."

Under an accident policy which, as shown by its heading, provides indemnity for loss of life, limb, sight, or time by accidental means, and loss of time by sickness, and in its body provides that for certain losses certain amounts shall be payable, and for loss of one eye \$2,500, and provides that if such bodily injury alone shall directly, immediately, and continuously disable insured from the duties of his business, and during the period of such total disability shall result in any of the losses specified, he shall be paid the sum provided for such "loss," and in addition the weekly indemnity for "disability," while "disability" must immediately follow an injury that the weekly indemnity therefor may be had, loss of an eye need not immediately follow the accident that the lump sum payable therefor may be recoverable.

(For other cases, see Insurance, Cent. Dig. §§ 1312, 1313; Dec. Dig. § 527.)

(For other definitions, see Words and Phrases, First and Second Series, Disability ; Loss.)

Appeal from Superior Court, City and County of San Francisco; George A. Sturtevant, Judge.

Action by Ernest Claxton against the American Casualty Company. Judgment for plaintiff, and defendant appeals. Affirmed.

W. C. Sharpstein, of San Francisco, for Appellant.
McClanahan & Derby, of San Francisco, for Respondent.

RICHARDS, J.

This is an appeal from a judgment in plaintiff's favor in an action for the recovery of an amount alleged to be due upon an

* Decision rendered, May 15, 1916. Rehearing denied by Supreme Court, July 13, 1916. 158 Pac. Rep. 544.

accident insurance policy for the loss of an eye. The only question presented is as to whether the complaint states a cause of action.

The complaint sets forth the policy of insurance in full, and then proceeded to aver that while it was in effect the plaintiff suffered an accidental injury to one of his eyes which for several days thereafter seemed trivial and did not give him much concern, but which gradually developed into a cataract which destroyed the sight of his eye. The policy of insurance, as shown by its heading—

“provides indemnity for loss of life, limb, sight or time by accidental means, and loss of time by sickness to the extent herein provided.”

In the body of the policy there is a provision that for the loss of both eyes the sum of \$5,000, and for the loss of one eye the sum of \$2,500 shall be payable. The policy also contains the following clause:—

“Part I.—If such bodily injury alone shall, directly and independently of all other causes, immediately, continuously and totally disable and prevent the insured from performing any and every kind of duty pertaining to his business or occupation, and if during the period of such continuous and total disability shall result in any one of the losses specified in part I hereof, the company will pay the sum specified for such loss, and in addition will pay the weekly indemnity as provided in part II from the date of the accident to the date of such loss.”

There are other clauses in the policy providing that for total disability the sum of \$25 per week shall be payable during the period of such continuous total disability not resulting in total loss, and that for partial disability a gradual payment shall be made depending upon the extent of the disability for a period not exceeding fifty-two consecutive weeks. It is the contention of the appellant that the provision of the policy above quoted in *hæc verba* limits the liability of the defendant to cases where the accident “immediately and continuously” disables and prevents the insured from performing the duties pertaining to his business or occupation, and that since in this case the complaint shows affirmatively that the accident and injury did not immediately or continuously cause the total loss of sight in the plaintiff’s injured eye, he cannot recover under the provisions of his policy, and hence that his complaint did not state a cause of action. We cannot give our assent to such a narrow and limited interpretation of this insurance policy. Read as a whole, it is evident that it was intended to provide for two modes of indemnity to injured policyholders: One, the payment of a stipulated sum for the loss of an eye; the other an indemnity in the form of weekly benefits to be paid the injured person during the period of his inability to attend to his business or occupation, resulting from the injury and extending from the date of such injury to the date of the

loss of the injured member. So construed, the terms of this policy are reasonable and consistent; while, on the other hand, to give the quoted clause the meaning which the appellant claims for it would be to limit the operation of the policy to cases where the accident was so severe as to immediately and continuously deprive the insured of the sight of his eye, and thus practically immediately create the loss. The use of the words "in addition" in the quoted passage clearly indicates the distinction to be observed between the terms "disability" and "loss" in this policy, and also serves to show that the intended scope of said provision was to define the conditions under which disability benefits would be payable, but not to prescribe the condition under which the lump sum payable for the loss of the plaintiff's eye should be due.

It follows from this broader and more reasonable and consistent construction of the policy that the complaint states a cause of action.

Judgment affirmed.

We concur: Lennon, P. J.; Kerrigan, J.

ST. LOUIS COURT OF APPEALS.

MISSOURI.

BRUNSWICK

vs.

STANDARD ACC. INS. CO. OF DETROIT, MICH. (No. 14380.)*

1. INSURANCE—CONSTRUCTION OF POLICY—WHAT LAW GOVERNS.

An accident policy issued to one residing in the city of St. Louis, and who died there, was to be interpreted in connection with the suicide statute of the state.

(For other cases, see *Insurance*, Cent. Dig. § 293; Dec. Dig. § 147[1].)

2. INSURANCE—ACCIDENT INSURANCE—SUICIDE—STATUTE—"ACCIDENTAL MEANS."

Under Rev. St. 1909, § 6945, providing that in suits upon policies of life insurance it shall be no defense that insured committed suicide, unless it appears that he contemplated suicide when he made his application, and that any contrary stipulation in the policy shall be void, an accident policy is regarded as a policy on the life of the insured, and where it insured against liability or death resulting directly, exclusively, and independently of all other parties from accidental bodily injury except when self-inflicted while insane, the defense of suicide

* Decision rendered, July 5, 1916. Rehearing denied, July 20, 1916. 187 S. W. Rep. 802.

will be rejected where insured came to his death as a result of "accidental means," that is through violence or otherwise, as by the intentional taking of an overdose of poison, and is also to be rejected in case of the insured's suicide, as suicide is regarded as an accident, permitting a recovery on the policy.

(For other cases, see Insurance, Cent. Dig. § 1185; Dec. Dig. § 465.)

(For other definitions, see Words and Phrases, First and Second Series, Accidental Means.)

Appeal from St. Louis Circuit Court; James E. Withrow, Judge.
"To be officially published."

Action by Pauline Brunswick against the Standard Accident Insurance Company of Detroit, Mich. Judgment for defendant, and plaintiff appeals. Case certified to the Supreme Court for final determination by reason of its conflict with the decision of another Court of Appeals.

Emerson E. Schnepp, Otto F. Karbe, and Taylor & Mayer, all of St. Louis, for Appellant.

Merritt U. Hayden, of St. Louis, for Respondent.

NORTONI, J.

This is a suit on a policy of accident insurance. The finding and judgment were for defendant, and plaintiff prosecutes the appeal.

Plaintiff is beneficiary in the policy issued by defendant to her husband, William Brunswick. The policy, as stated, is one of accident insurance in that it stipulates insurance on William Brunswick against disability or death resulting directly, exclusively, and independently of all other causes from accidental bodily injuries except when self-inflicted while insane. There is no substantial evidence tending to prove an "accident," as that term is commonly understood and accepted, but it is said plaintiff's husband committed suicide.

[1] There is ample evidence in the record tending to prove that the insured, plaintiff's husband, while the policy was in force and effect, committed suicide through taking poison, that is, cyanide of potassium. It sufficiently appears that the policy was issued to Brunswick in the city of St. Louis, where he resided, and in which city he subsequently died, and therefore it is to be interpreted in connection with our suicide statute.

At the instance of defendant, the court gave the two following instructions:—

"(1) The court instructs the jury that if you find and believe from the evidence that the death of William Brunswick was caused in any other manner or by any other means than by accident, then the plaintiff cannot recover, and your verdict must be for the defendant.

"(2) You are instructed that, even though you may find from the evidence that William Brunswick took cyanide of potassium, on the day of his death, and even though you may further find that his death was caused thereby, there is still no presumption in

law that his act in taking said poison, if you find that he did take it, was accidental, or that his death resulted from accidental bodily injuries. On the contrary, the burden is upon the plaintiff to prove that the death of said William Brunswick resulted, independently of all other causes, from accidental bodily injuries, and, unless she has proved such fact, she cannot recover, and your verdict must be for the defendant."

It is argued the court erred in so instructing the jury, in that under the law suicide is deemed an accident within the policy when construed together with our statute (section 6945, R. S. 1909). The statute is as follows:—

"In all suits upon policies of insurance on life hereafter issued by any company doing business in this state, to a citizen of this state, it shall be no defense that the insured committed suicide, unless it shall be shown to the satisfaction of the court or jury trying the cause that the insured contemplated suicide at the time he made his application for the policy, and any stipulation in the policy to the contrary shall be void."

[2] There is no suggestion in the case that the insured contemplated suicide at the time of taking out the policy sued upon, and the matter is to be considered alone on the face of the policy as influenced by the statute quoted. When there is evidence tending to prove the insured came to his death as a result of accidental means—that is, through violence or otherwise—as by the unintentional taking of an overdose of poison or something of that character, it appears to be well enough that the defense of suicide should be rejected under this statute, for a policy of accident insurance is regarded as one on the life of the insured. See *Logan vs. Fidelity & Casualty Co.*, 146 Mo. 114, 47 S. W. 948. But though such be true, it is indeed difficult to perceive on what principle suicide, which is the intentional taking of one's life, may be said to be an accident within the terms of the policy, even as influenced by the statute. However that may be, the course of decision seems to sustain the view that suicide is to be regarded as an accident, and a recovery may be had on an accident policy when the death results from the act of the insured intentionally taking his own life as if it occurred through accidental means. In *Whitfield vs. Aetna Life Ins. Co.*, 205 U. S. 489, 27 Sup. Ct. 578, 51 L. Ed. 895, the policy involved was one of accident insurance, as here, and it was admitted in the pleadings that the insured "died from bodily injuries caused by a pistol shot fired by himself, and the cause of his death was suicide." Moreover, the case was submitted on an agreed statement of facts, which recited that the insured—"died from bodily injury caused by a pistol shot intentionally fired by himself for the purpose of thereby taking his own life; that the cause of the death of said Whitfield was suicide."

On these facts the question of liability under an accident policy was considered in connection with our suicide statute above

quoted by the Supreme Court of the United States, which gave judgment to the effect that the plaintiff was entitled to recover the full amount of the policy sued on. Subsequently this court, in Applegate vs. Travelers' Ins. Co. of Hartford, Conn., 153 Mo. App. 63, 90, 132 S. W. 2, 11, considered the matter of a suicide through the taking of poison, as here, and enforced a recovery on an accident policy considered together with our suicide statute. In that case the court said:—

"The policy, as interpreted by the law and by the courts, does provide that when death occurs from suicide, whether that suicide is accomplished by poison or by shooting, the beneficiary shall recover for the full amount insured to be paid by reason of death occurring."

If these judgments are sound, then suicide is to be regarded as an accident within the terms of the policy, and the instructions above set forth are erroneous.

The judgment should be reversed and the cause remanded. It is so ordered.

Allen, J., concurs. Reynolds, P. J., concurs in result only, not agreeing to the apparent doubt cast upon the correctness of the holding in the Whitfield and Applegate decisions, *supra*.

NORTONI, J.

Since the above opinion was filed, the attention of the court has been directed to the case of Scales vs. National Life & Accident Ins. Co., 186 S. W. 948, recently decided by the Springfield Court of Appeals, which appears to reflect a contrary view. This case should therefore be certified to the Supreme Court for a final determination in accordance with the mandate of the Constitution as in conflict with the case last cited. It is so ordered. All concur.

REYNOLDS, P. J. (concurring).

This case is to be certified to the Supreme Court as in conflict with the decision of the Springfield Court of Appeals in Scales vs. National Life & Accident Ins. Co., not yet officially reported, but see 186 S. W. 948, the opinion in that case filed May 25th, 1916, after our court had filed its opinion in the case at bar and not brought to our attention until after we had filed our opinion in it, which we did July 5th, 1916. I think it proper to add a few words to what I said in my concurring opinion in the case at bar. There I said that while agreeing to the reversal and remanding of the case I could not agree to the apparent doubt cast upon the correctness of the holding of the United States Supreme Court in Whitfield vs. Aetna Life Ins. Co., 205 U. S. 489, 27 Sup. Ct. 578, 51 L. Ed. 895, or of our court in Applegate vs. Travelers' Ins. Company of Hartford, Conn., 153 Mo. App. 63, commencing at page 90, 132 S. W. 2. I add to the above that since reading the very learned and elaborate opinion by my brother Farrington, speaking for the Springfield Court of Appeals in the Scales Case,

supra, I think that that opinion is contrary to what was held by our court in *Keller vs. Traveler's Ins. Co.*, 58 Mo. App. 557, as well as in the Applegate Case, supra, and by what is held by our Supreme Court in *Logan vs. Fidelity & Casualty Co.*, 146 Mo. 114, 47 S. W. 948, as well as by the Supreme Court of the United States in construing our suicide statute. It is clear to me that if the view taken by the Springfield Court of Appeals in the Scales Case is correct, its effect is not only to overturn those decisions but to evade and nullify our suicide statute (Revised Statutes 1909, sec. 6945). It is not pretended in this case that at the time the insured made his application for the policy he contemplated suicide. It is also clear that at the time of taking out the policy he was a citizen of this state. So that this section 6945, as it seems to me, is directly applicable here. That must be so unless it is held that this section does not apply to accident policies. As a matter of fact suicide is never an accident but is always, in the case of a sane man, premeditated, and unless we hold contrary to the former decisions of our court in the Keller and Applegate Cases and of our Supreme Court in the Logan Case, and of the Supreme Court of the United States in the Whitfield Case, every one of which were cases of suicide, it must follow that the result arrived at by the Springfield Court of Appeals in the Scales Case is erroneous.

It is not to be overlooked, moreover, that the decision of the Supreme Court of the United States in the Whitfield Case was directly in line with what that court had held in *Knights Templars' and Masons' Life Indemnity Co. vs. Jarman*, 187 U. S. 197, 23 Sup. Ct. 108, 47 L. Ed. 139. The opinion in the last mentioned case was written by Mr. Justice Brown and concurred in by all the Justices of the Supreme Court except Mr. Justice Harlan, who, as reported, took no part in its decision. But afterwards Mr. Justice Harlan wrote the opinion of the court in the Whitfield Case. So we have the unanimous holding of the Justices of the United States Supreme Court sustaining and applying our suicide law to accident policies. As I understand the decisions of our own court, of our Supreme Court and of the Supreme Court of the United States, the defense of suicide, whether by shooting, hanging or taking of poison, is no defense under our statute against the payment of the principal sum to the beneficiary of an accident policy and that the insurance company cannot limit its liability below that amount by any provision either denying any compensation in case of suicide or diminishing the amount to be paid when death is the result of suicide. I think the decision of the Springfield Court of Appeals in the Scales Case is not only contrary to what we have here held, but what our own court, our Supreme Court, and the Supreme Court of the United States has held in the cases I have cited.

SUPREME COURT OF MISSOURI.

DIVISION No. 1.

FAY**v.s.**

AETNA LIFE INS. CO. (No. 17914.)*

2. INSURANCE—ACCIDENT INSURANCE—RISK—“PASSENGER.”

Under such policy the insured, who started to enter a street car which was standing still with its doors open for the admission of passengers, with the intent to ride thereon, was a passenger, giving the word “passenger” in the policy the ordinary accepted meaning, notwithstanding those in charge of the car closed the door before he had fully entered the car.

(For other cases, see Insurance, Cent. Dig. § 326; Dec. Dig. § 169.)

(For other definitions, see Words and Phrases, First and Second Series, Passenger.)

4. INSURANCE—ACTION ON POLICY FOR DAMAGES FOR VEXATIOUS DELAY—PLEADING.

Under Rev. St. 1909, § 7068, providing that in an action on an insurance policy, where it appears that the insurer has vexatiously refused to pay such loss, plaintiff may be allowed damages not exceeding 10 per cent on the amount of the loss and a reasonable attorney's fee, the plaintiff, desiring to recover such damages, must by his petition show that he claims and is entitled thereto.

(For other cases, see Insurance, Cent. Dig. § 1607; Dec. Dig. § 638.)

5. INSURANCE—ACTION ON POLICY—DAMAGES FOR VEXATIOUS REFUSAL TO PAY—PROOF.

Where such damages are appropriately alleged, they may be proven by any competent evidence whether such evidence tends to establish the main issue, the right to recover the amount of the policy or not.

(For other cases, see Insurance, Cent. Dig. § 1554; Dec. Dig. § 645[4].)

6. INSURANCE—ACTION ON POLICY—DAMAGES FOR VEXATIOUS REFUSAL TO PAY—QUESTION FOR JURY.

Where the issue as to damages for vexatious delay is not made out by proof, the court should take such issue from the jury by appropriate instruction, but if there is any evidence of vexatious refusal, the issue should be submitted to the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1744, 1762; Dec. Dig. § 668[10].)

7. INSURANCE—ACCIDENT INSURANCE—ACTION ON POLICY—DAMAGES FOR VEXATIOUS REFUSAL TO PAY—EVIDENCE.

An action to recover under accident policy for double indemnity where insured was injured while a passenger on a public conveyance was brought after a settlement for the amount of the policy, and after the

* Decision rendered, June 2, 1916. Motion to transfer to Court in Banc overruled, July 3, 1916. 187 S. W. Rep. 861.

insured had received a receipt in full for all liability, given when the plaintiff had no knowledge of the existence of such double indemnity provision. Defendant first pleaded settlement, and, after a replication, alleging that such settlement had been fraudulently procured and tendering the amount received in settlement, then moved the court to compel plaintiff to pay into court the amount received in settlement upon a return of the receipt therefor. After such motion was overruled an answer framed so as to obviate the question of fraud in the release, but denying liability, was filed. *Held*, evidence as to the various charges in the pleadings and the avoidance of the issue of settlement, was competent to show a vexatious delay in payment.

(For other cases, see Insurance, Cent. Dig. §§ 1669, 1676; Dec. Dig. § 648[1].)

Appeal from Circuit Court, Jackson County; William O. Thomas, Judge.

Action by Nellie Fay against the Aetna Life Insurance Company. Judgment for plaintiff with attorney's fees, and defendant appeals. Affirmed.

J. C. Rosenberger, R. E. Talbert, and F. R. Wolfers, all of Kansas City, for Appellant.

T. J. Madden and Bird & Pope, all of Kansas City, for Respondent.

GRAVES, P. J.

Plaintiff is the widow of William H. Fay, deceased. Defendant issued to Fay an accident insurance policy on January 17, 1907. This policy was for \$5,000, and issued for one year, but was kept in force to the time of Fay's accidental death, January 10, 1912, by annual renewals thereof. The policy provided for accumulations, and by a "rider" or subsequent agreement entered into by the company at the date of Fay's death the policy would and did amount to \$7,500.

The policy was payable to plaintiff, and for the accidental death of her husband she under the terms of the policy as modified by this subsequent agreement or rider of date February 12, 1907, was entitled to \$7,500. In this policy was a double liability clause which entitled plaintiff to recover double the amount, if Fay was accidentally killed whilst a passenger "in or on any railway passenger car propelled by mechanical power." This clause as originally found said nothing about a passenger riding upon the steps or platform of a car. The defendant, still bidding for business, in June, 1910, broadened this double liability clause of its contract so that thereafter the policy of Fay had incorporated therein the following:—

"Double Indemnities.

"(7) If such injuries are sustained by means as aforesaid while the insured is a passenger in or on a public conveyance provided by a common carrier for passenger service (including platform, steps, or running board of railway or street railway cars), * * * the amount to be paid under sections 1, 5, and 6 should be double the sum otherwise payable for such injuries."

So that, in the language of the distinguished counsel for appellant, as found in the brief:—

"On January 10, 1912, the date of insured's death, the amount of his policy had increased from \$5,000 to \$7,500 through continuous renewal in case of his death from ordinary accident, and to \$15,000 in case the injuries were sustained by him 'while the insured is a passenger in or on a public conveyance provided by a common carrier for passenger service (including platform, steps, or running board of railway or street railway cars).'"

This amendment to the original policy (in insurance language called a "rider") was not found by Mrs. Fay when she came to adjust the matter with defendant. It was not with the policy, but was afterward found in some of Mr. Fay's private papers at his office. Mrs. Fay, through her counsel, settled with defendant for \$7,500, and gave defendant a receipt in full for all liability, without the knowledge of the existence of this supplemental agreement or rider of June, 1910, by which the terms of the policy were amended as aforesaid. Shortly after the settlement this rider or amendment to the policy was discovered, and plaintiff demanded of defendant the additional sum of \$7,500, on the theory that deceased was a passenger upon the steps of a Metropolitan Street Railway car at the time of his accidental death. The defendant declined to pay this additional sum, and the instant suit followed. It should be noted that this change in the double liability clause, as above indicated, was one being made on policies generally by defendant, and defendant had full knowledge of this amendment to the policy when it settled with Mrs. Fay for \$7,500.

The course of the pleadings may be of importance. Counsel for appellant has thus described the various steps in the pleadings before issue was finally made:—

"In her petition: (1) Plaintiff pleads the provisions of the double indemnity clause which limits its benefits to accidental injuries sustained 'while the insured is a passenger'; (2) and alleges that Wm. H. Fay was accidentally killed by falling from a street railway car of the Kansas City Elevated Railway Company 'on which he was a passenger'; (3) alleges that thereby the company became liable to her for \$15,000, 'but said defendant, instead of paying to this plaintiff the sum of \$15,000, to which she was entitled, paid her only the sum of \$7,500, instead of said full amount of \$15,000.'

"To this petition defendant pleaded in bar of plaintiff's action the settlement and release executed by her in consideration of \$7,500, and as a further defense denied that Fay, the insured, was a passenger on the street car, or that the plaintiff was entitled to any double indemnity, or that defendant was in any way indebted to the plaintiff.

"Thereupon plaintiff filed an amended petition with substantially the same allegations, but adding the allegation that 'defendant has

vexatiously refused to pay the additional sum of \$7,500 to this plaintiff,' and prays judgment for \$7,500, and interest, and also for \$750 damages as a penalty for said vexatious refusal of defendant to pay plaintiff said \$7,500, and for the further sum of \$2,500 as attorney's fees.

"To this petition defendant filed its former answer.

"Thereupon plaintiff filed her reply charging in general terms that the release had been obtained by fraud, making free use of the words 'fraud and fraudulent,' but setting forth no facts from which fraud could be inferred. The gist of these allegations is that at the time the company paid Mrs. Fay the \$7,500 she did not know she was entitled, as she claims, to \$15,000, but that defendant did know this and fraudulently concealed said fact."

In her reply plaintiff also offered to return to the defendant the sum of \$7,500 received by her; said offer being set forth in the reply as follows:—

"The plaintiff here now offers and tenders to said defendant said sum of \$7,500 alleged as such full satisfaction and discharge of plaintiff's said claim and demand, as set forth in said second amended petition herein, and offers to comply with any order of the court with reference thereto."

Plaintiff did not, however, with her reply, making offer of restitution, pay the money into the court or tender it to the defendant, or do anything else to make her offer good.

Accordingly, on September 13, 1912, defendant filed in the court its formal motion in which it accepted plaintiff's offer to rescind the release and to return the \$7,500, and praying that an order be made requiring plaintiff to make good her offer by paying said \$7,500 into court; otherwise that her petition be stricken from the files. Defendant's motion last above referred to was overruled by the court on November 9, 1912, and it took a term bill of exceptions.

Later, on December 10th, the defendant filed an amended answer in which it formally of record withdrew its plea of settlement and release and narrowed the controversy down to the single issue as to whether or not Fay at the time he was injured was a passenger on the car, and therefore, whether he was entitled to the single indemnity of \$7,500 already admittedly paid to plaintiff, or whether she was entitled to a further payment of \$7,500 by way of the double indemnity.

The company by this answer in effect expressed its willingness to litigate with Mrs. Fay her right to recover the additional \$7,500, notwithstanding defendant had already paid her \$7,500 in full settlement, and although she had executed a release fully discharging the company, so that she was thereby restored to her original cause of action, while at the same time retaining the fruits of the settlement. But the plaintiff was not to be denied in her charges of fraud. Although the release had been withdrawn as a defense by the amended answer, and was no longer being

pleaded as a defense, plaintiff filed a reply renewing the charge that defendant had procured the release by fraud. This reply was filed after the trial began, and under it and over defendant's objections the court allowed plaintiff to introduce evidence in the effort to support such charges of fraud in the release, although no such issue was properly in the case; the court ruling:—

"I think, Mr. Rosenberger, that the character of the testimony referred to would be admissible under the reply which was filed in this case."

And in arguing for the reception of this class of evidence plaintiff's counsel said:—

"The object and purpose of this testimony is to show the vexatious conduct of this defendant in refusing to pay this woman's claim."

Fruitless objections were made throughout by defendant to the reception of this class of evidence and proper exceptions saved. We quote the foregoing because it is a short and concise statement of the steps taken to get this case to an issue. The argumentative part of the statement as to the substance of the allegations of fraud need not be strictly taken. On this the reply will best speak. Plaintiff obtained the following verdict:—

"We, the undersigned jurors, find the issues in favor of the plaintiff and assess the amount of her recovery under said policy the sum of (\$7,500.00) seventy-five hundred dollars and (\$337.50) three hundred and thirty-seven and $\frac{50}{100}$ dollars, interest, and also assess the amount of (\$1,250.00) twelve hundred and fifty dollars as attorney's fees. [Here follow the signatures of ten jurors.]"

From a judgment entered upon such verdict, the defendant has appealed.

[1, 2] I. Defendant first insists upon its demurrer to the testimony, as we gather the contentions made. As the issues were finally made, the sole question on the merits of the case was whether or not the deceased was a passenger upon the street car at the time of the fatal accident. This question turns upon the facts.

The sole question of fact was whether or not the deceased was boarding a street car before the car started, and whilst the door was yet open for the admission of passengers. The evidence for plaintiff tended to show that the car stopped at the usual place for the passengers to alight from such car and to get on said car; that whilst the car was in this position the deceased attempted to enter such car, but whilst he was on the step or partially on the step the conductor closed the door (previously standing open) and gave the signal for the car to go forward, and it did go forward, with plaintiff clinging to the handholds, with foot on step, until he was knocked to the street below by a structure on the side of the tracks. This structure was not far from where the car stopped and started. It was an elevated railroad passing over

the street. For defendant there was much evidence to the effect that plaintiff ran and tried to board a moving car after the door through which passengers were admitted had been closed. The evidence for plaintiff made him a passenger, whilst that for the defendant did not. Much stress is placed upon the character of the two witnesses upon whom the plaintiff relied to prove that deceased had done the things required by the law to make him a passenger. Likewise counsel for plaintiff attacks some of the evidence for the defendant. The weight and credibility of this evidence was for the jury, and they have determined it against the defendant. The matter was submitted on the following instruction:—

“If the jury believe and find from the evidence that on January 10, 1912, the Kansas City Elevated Railway Company was a carrier of passengers for hire and used the railroad and car mentioned in the evidence for such purpose, and if you further find and believe from the evidence that on said day the employees of said Kansas City Elevated Railway Company in charge thereof stopped said car at or near a point where the tracks of said railway company cross the state line between the states of Missouri and Kansas for the purpose of receiving passengers, and, if you further find that William H. Fay, with the intention in good faith to become a passenger (if you so find), had gone up the steps and through the station at said state line and before the doors of said car were closed, and before said car had started, he was in the act of stepping upon the steps of said car to become a passenger thereon, then the court instructs you that said Fay was a passenger on said car. And, if you further find and believe from the evidence that said Fay was a passenger as above defined and had actually gotten onto the steps of said car and was standing thereon when he was caused to fall therefrom and to be killed by falling from the said steps of said car at said point to the street below (if you so find), then said Fay was a passenger on said car within the meaning of the terms of said insurance policy and the additional benefit, indorsement extending the benefits under said policy, and which are in evidence in this case. And, if the jury further believe and find from the evidence that said Fay was caused to be so injured and he died as a direct result of said injuries, if any, received at said time and place, then the plaintiff is entitled to recover. And you are further instructed if you find for the plaintiff you will find for her in the sum of \$7,500, together with interest thereon at the rate of 6 per cent per annum from the date of demand of payment, if any, as shown by the evidence. And, if you further believe and find from the evidence that defendant has vexatiously, that is, without reasonable cause, refused to pay such amount or loss, then you may, in addition to the above amount and interest, allow the plaintiff damages not to exceed 10 per cent on the above amount, and a reasonable attorney's fee, but the amount which you may allow plaintiff, if

any, for such attorneys' fee must not in any case exceed the sum of \$2,500."

In so far as this instruction undertakes to outline the facts necessary to make deceased a passenger, it is correct. If, as a fact, the car was standing still, with its door open for the admission of passengers, and whilst it was so standing the deceased started to enter the same, with the intent to ride thereon as a passenger, he was a passenger within the eyes of the law, although the employee of the railway closed the door upon him before he had fully entered such car. The stopping of the car and the opening of the door was an invitation by the company to deceased to become a passenger, and when he (if he did) attempted to board such car whilst it was yet standing with door ajar, for the purpose of riding thereon, he at that moment became a passenger. 6 Cyc. p. 539.

The word "passenger" in the policy has the ordinary accepted meaning. In other words, if the deceased would be classified as a passenger in an action against the carrier, he should likewise be deemed a passenger under the terms of an accident insurance policy unless the terms of the policy added some conditions. This policy required such passenger to at least be on the steps of the car.

We shall not further follow the counsel upon either side in their assault upon witnesses. The jury weighed the testimony of these witnesses. It was shown that deceased had been crippled a few days before the fatal accident, and had to use a cane in walking. This cane was found near him when picked up after the accident. The jury were evidently loth to believe that a cripple had run and caught hold of a moving car in an attempt to ride.

The question of passenger or no passenger was fairly submitted for determination by the jury, and their verdict is conclusive here upon that question.

[3] II. This instruction supra given for plaintiff is criticized by counsel for appellant thus:—

"This instruction was self-contradictory and misleading. It first erroneously told the jury that Fay was a passenger on this car if with the intention to become a passenger he approached the car and was in the act of stepping on the steps of said car, intending to become a passenger thereon. This was erroneous. By the terms of the policy plaintiff could not recover in this case unless the injuries were sustained 'while the insured is a passenger in or on a public conveyance' (see policy). In other words, by the terms of the contract it was essential that Fay should not only be a passenger, but that he should be either in or on the car. Neither his presence at the station nor the fact that he was in the act of stepping on the steps of the car made him a passenger on the car. His mere intention to get on the car was not equivalent to his being on the car. His actual presence on the car as a passenger was essential to a right of recovery. In the next sentence

the court tells the jury that, if they find that Fay was a passenger 'as above defined,' and had actually gotten onto the steps of the car, then insured was a passenger, and plaintiff was entitled to recover. In other words, the court first told the jury that Fay was a passenger on the car if he was in the act of stepping upon it, which was erroneous, and the court then tells the jury that, if he was in the act of stepping on the car, and had actually gotten upon the step, then he was a passenger and to find for the plaintiff, and this latter regardless of whether the car by that time had then started, its door was closed or not. The jury could very well have understood from this instruction that the plaintiff had the right to recover if Fay was in the act of getting on the car, even though he had not in fact gotten on it.

"We submit that the court tried this case upon a wholly erroneous theory in admitting affirmative and independent evidence of vexatious refusal to pay; that in no event should that fatally prejudicial evidence have been admitted as part of the plaintiff's case in chief; that the evidence abundantly justified the defendant in contesting this claim, and therefore the court was not warranted in even submitting the question of vexatious refusal to the jury; that the court erred in refusing to withdraw that issue from the jury; that the errors committed permeated the whole trial and inhere in the verdict itself, not merely with respect to attorneys' fees, but with respect to the whole verdict.

"The judgment should accordingly be reversed."

It does not appear that defendant could have been harmed by this instruction, because the instruction requires the jury to find that deceased "had actually gotten on the steps of said car and was standing thereon when he was caused to fall" before the jury could find for the plaintiff. The writer of the instruction evidently had in mind what acts were necessary to make deceased a passenger, as between him and the railroad company, and thus the first clause of the instruction. Technically, as between deceased and the railway, he was a passenger, whether he got on the steps or not, provided the other assumed facts were true. But, as the policy required the passenger to be "in or on the car," the writer added the clause last quoted above which required the jury to find that this technical passenger was actually on the car, as required by the policy. There is no substance in the complaint, and this contention of appellant is not sustained.

[4-6] III. The most vehemently argued error in this record is thus stated in the conclusion of counsel's able written argument in the brief. The contention is that under section 7068, R. S. 1909, the plaintiff should not be allowed to introduce evidence as tending to show vexatious refusal to pay a policy of insurance, unless such evidence was necessary and proper for the purpose of establishing plaintiff's right to recover under the policy itself. To couch the question in counsel's language, we quote the brief thus:—

"The whole test of the good faith of the company's refusal is the strength or weakness of its case as presented at the trial, and it is erroneous to receive extrinsic and collateral evidence disconnected with the merits, directed solely to the issue of vexatious refusal. This is mere 'side-wind evidence' preventing a fair trial."

The statute reads:—

"In any action against any insurance company to recover the amount of any loss under a policy of fire, life, marine, or other insurance, if it appear from the evidence that such company has vexatiously refused to pay such loss, the court or jury may, in addition to the amount thereof and interest, allow the plaintiff damages not exceeding 10 per cent on the amount of the loss and a reasonable attorney's fee: and the court shall enter judgment for the aggregate sum found in the verdict."

Whilst there may be some authority from other states under statutes of those states, which would lend some support to appellant's contention, our statute cannot be so construed. Under our statute, if the plaintiff desires to recover the damages named therein, i. e., the 10 per cent on the amount of the loss and the attorney's fees, there must be appropriate allegations in the petition showing that plaintiff claims and is entitled to these damages, and such allegations must be sustained by the proof. Numerous things done by the defendant might be evidence of a vexatious refusal to pay, and yet not have any bearing upon the right of plaintiff to recover on the policy. Thus in *Young vs. Insurance Co.*, 187 S. W. 856, not yet officially reported, we held that the threat to litigate through the Supreme Court, if a settlement offered was not accepted, tended to show a spirit of vexatious delay. This threat did not prove plaintiff's case, but it did prove an intent to vexatiously delay payment. But we need not mention instances. It stands to reason that under this statute plaintiff must have in the petition allegations showing that he is entitled to these damages, and these damages become a triable issue in the case. As it is a triable issue, any evidence which tends to prove this particular issue is competent, whether such evidence tends to prove the main issue in the case or not. By main issue we mean the plaintiff's right to recover under the policy. Of course, if this issue as to these statutory damages is not made out by proof, it is the duty of the court, as in other cases, to take such issue from the jury by appropriate instruction. But, if there is evidence by proof direct of vexatious refusal to pay, or if from all the evidence, facts, and circumstances in the case the jury has the right to infer a vexatious refusal to pay, then the issue should be submitted to the jury. The statute leaves the jury as the arbiter, if there are facts sufficient to carry the issue of vexatious delay to the jury. Nor could the plaintiff be precluded from introducing any competent evidence tending to show a vexatious delay in payment. Such plaintiff is not confined upon this issue merely to matters and things which would tend to show

defendant's liability for the principal sum of the policy, but he may offer any competent evidence upon this one issue, whether such evidence supports the main issue of liability on the policy or not. Certainly there can be no recovery upon the issue of vexatious delay, if there is no recovery under the policy, but, if there is recovery on the policy, then there may be a recovery of these statutory damages, if the jury so find, under evidence sufficient to support their verdict upon that issue. This particular question —i. e., whether extrinsic evidence is admissible to sustain the allegation of vexatious delay—is one of first impression in this state. The statute has been frequently under review, but not from this angle. In the very early case of *Brown vs. Ins. Co.*, 45 Mo. loc. cit. 227, we said:—

"The whole question of vexatious refusal or delay is a matter of fact to be determined by the jury. They must make up their verdict on this issue by a general survey of all the facts and circumstances in the case; and if, upon a full consideration, they conclude that the refusal was unjustifiable and vexatious, the law authorizes them to assess the damages. The statute will not admit of the construction contended for by the counsel for the plaintiff in error that before damages are allowed it must be explicitly proven by the plaintiff that the delay or refusal was vexatious."

And this doctrine has the later express approval of this court in *Keller vs. Insurance Co.*, 198 Mo. 440, 95 S. W. 903. In the Brown Case there was no extrinsic proof on the question of vexatious delay, as we gather it from the opinion, but Judge Wagner did not by the language used undertake the rule that proof on the question of vexatious delay must be limited to proof tending to show the right of plaintiff to recover upon the merits. It is there simply ruled that the jury should determine this question from the facts and circumstances in the case. In that case there was a wholly untenable defense made upon the question of the validity of the policy, and it was evidently upon this matter that the court ruled there was sufficient evidence to submit the question to the jury.

In the case at bar we rule that the allegation of vexatious delay in payment of the policy may be shown by any competent evidence, whether such evidence tends to establish the right to recover the policy amount or not. This leaves but one question of serious import left, and that is the competency of the evidence offered in the trial upon the issue. That question we take next.

[7] IV. Recalling the statement of facts, it will appear that defendant first pleaded settlement, to which plea plaintiff replied by alleging such settlement was fraudulently procured, and tendering in the reply the \$7,500 received in settlement. Later the defendant moved the court to compel plaintiff to pay into court the \$7,500 upon a return of the receipts taken in settlement. This motion was overruled, and the defendants so framed their answer as to obviate the question of fraud in the release, if they

could obviate that issue. In this last answer they did not plead settlement, but denied liability. The plaintiff proved these pleadings on the theory that they tended to show a vexatious delay in payment. We think this evidence competent. It will not do to say that defendant magnanimously withdrew the issue of settlement merely to save plaintiff the trouble of trying to prove fraud in the execution of the releases. We use the term "releases" instead of "release" purposely, because, when plaintiff brought in her policy and released all claims upon it for the \$7,500, she was asked about the annual renewals issued by the company, and she not having them, they took a further release as to them. The officer of the company also said that they had in mind the last rider pertaining to double liability when this settlement was made. The jury were entitled to all these facts. They might conclude that the issue of fraud in the settlement was skillfully withdrawn by defendant's last answer to obviate a trial of an issue, which defendant feared in the case. The jury might reasonably conclude that this was but another link in the chain of vexatious delay.

Not only was this evidence proper, but, if plaintiff could show that the defendant purposely delayed the payment of the last \$7,500 by fraudulently procuring the release, that evidence would also be proper upon the issue of vexatious delay. In *Young vs. Insurance Co.*, supra, we held that the fact of a fraudulent appraisement had been procured by defendant was a proper matter to be considered upon the issue of vexatious delay. So in this case the procuring of a fraudulent release (if such was done) for less than the full liability of defendant was a proper circumstance to be shown upon the issue of vexatious delay, and this is none the less true because the showing of such fact might tend to prejudice the jury upon the main issue. If, as a fact, a fraudulent release was procured, it was the act of the defendant, and defendant should be estopped from saying that proof of its wrongdoing would prejudice the jury, if such proof is competent upon any issue in the case.

Plaintiff also showed that defendant went to the railway company to get the facts as to whether or not the deceased was a passenger, and that the railway company usually husbanded the witnesses who would testify to facts showing that such relation did not exist between it and deceased, and that defendant's agent making the investigation knew, that such was the course of conduct upon the part of the railway company.

We see no error in this evidence. Before refusing to pay on the ground that deceased was not a passenger, the defendant should have made a fair investigation of the facts. It should not have confined its investigation, as it seemingly did, to such facts as might have been given it by the railway company, which was vitally interested in the fact whether or not deceased was a passenger. Whether the railway was in the habit of getting one side

of the controversy in such case, if such was a fact, and defendant knew of this habit, was certainly competent. Other points are raised, all of which we have examined, but the foregoing are all that we deem worthy of note in the opinion. We believe that there were facts sufficient to carry the issue of vexatious delay in payment to the jury, and its finding thereon is binding here.

The judgment should be and is affirmed. All concur; Bond, J., in result.

SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FIRST DEPARTMENT.

HOPKINS

vs.

CONNECTICUT GENERAL LIFE INS. CO.*

1. INSURANCE — REGULATION — APPROVAL OF POLICY — STATUTE.

Under Laws 1913, c. 155, § 2, amending Insurance Law (Consol. Laws, c. 28) § 107, subd. (i), providing that a policy issued in violation of the section shall be valid, but the rights of the parties shall be governed by the provisions of the section, and subdivision (a), forbidding the issuance of an insurance policy, the form of which has not been filed with and approved by the superintendent of insurance, where defendant issued to plaintiff's intestate an insurance policy in the standard form, but containing a war rider which had not been filed or approved, the war rider was in violation of the statute, and will be discarded, and the policy is valid and enforceable in its standard form, which covered the risk exempted by the war rider.

(For other cases, see Insurance, Cent. Dig. §§ 246-249, 252; Dec. Dig. §§ 138[1], 140.)

2. INSURANCE—REGULATION—STATUTE—CONSTRUCTION.

Laws 1913, c. 155, § 2, amending Insurance Law (Consol. Laws, c. 28) § 107, subd. (i), providing that a policy issued in violation of the section is valid, will be construed as provided in the section, that when any provision in such policy is in conflict with any provisions of the section the rights and duties of the parties shall be governed by the provisions of the section, and it is not limited in its application to the standard provisions mentioned in subdivisions (c), (d), and (e).

(For other cases, see Insurance, Cent. Dig. § 252; Dec. Dig. § 140.)

3. INSURANCE — REGULATION — STATUTE—CONSTRUCTION.

Laws 1913, c. 155, § 2, amending Insurance Laws (Consol. Laws, c. 28) § 107, subd. 1, providing a penalty for wilful violation of its provisions does not provide the only penalty following a violation of the law of

* Decision rendered, July 10, 1916. 160 N. Y. Supp. 247.

...filing, or affect the interpretation of subdivision (i), providing that invalid provisions in policies shall be disregarded.

(For other cases, see Insurance, Cent. Dig. § 252; Dec. Dig. § 140.)

4. INSURANCE—ILLEGAL CONTRACTS.

The signature of the insured could not make valid a provision of an insurance policy which did not comply with the law, and which was expressly forbidden by law under important considerations of public policy.

(For other cases, see Insurance, Cent. Dig. §§ 263, 264; Dec. Dig. § 142.)

5. INSURANCE—REGULATION—STATUTE—CONSTRUCTION.

Under the provisions of Laws 1913, c. 155, § 2, amending Insurance Law (Consol. Laws, c. 28) § 107, providing for the approval of insurance policies by the Insurance Commissioner and that provisions not so approved shall be disregarded, the enforcement of only the valid provisions of a policy was not enforcement of a contract which the parties did not make, since the insurer must have known that a war rider attached to the policy of deceased was invalid, because it had not been approved by the Insurance Commissioner.

(For other cases, see Insurance, Cent. Dig. § 252; Dec. Dig. § 140.)

Clark, P. J., dissenting.

Appeal from Trial Term, New York County.

Action by May Davies Hopkins against the Connecticut General Life Insurance Company. Judgment for defendant (158 N. Y. Supp. 79), and plaintiff appeals. Reversed, and judgment directed for plaintiff.

Argued before Clarke, P. J., and McLaughlin, Scott, Dowling, and Davis, JJ.

Warren C. Van Slyke, of New York City, for Appellant.
George Coggill, of New York City, for Respondent.

DAVIS, J.

The defendant recovered a judgment against the plaintiff, dismissing the complaint, with costs. The case was tried without a jury, the parties having waived a jury trial.

[1] The action was brought upon an accident insurance policy issued to Albert L. Hopkins, which provided for the payment of \$40,000 to his wife, the plaintiff, in the event of his death resulting from injuries insured against in the policy. Mr. Hopkins went down with the Lusitania, which concededly was destroyed by a German submarine. There was a so-called "war rider" attached to the policy when issued, and the defense, successfully urged at the trial, is based upon the validity of this rider. But for this war rider, the plaintiff concededly was entitled to a recovery, as all of the facts sustaining such recovery were admitted by the pleadings and the stipulation introduced in evidence on the trial, and have been found in the decision. There were two riders attached to the policy when it was delivered to Mr. Hopkins. The war rider was signed by Mr. Hopkins and is as follows:—

"Rider to be Attached to and Form Part of Policy No. CF6674 Issued by the Connecticut General Life Insurance Company to Albert Lloyd Hopkins. In consideration of the issuance of the policy, I hereby agree for myself, my beneficiary, our respective executors, administrators, or assigns, that this policy does not cover any loss or disability resulting from bodily injuries caused directly or indirectly by any act of any of the belligerent nations engaged in the present European war."

"Dated this 29th day of April, A. D. 1915.

"Connecticut General Life Insurance Company,

"Wells, Potter, Fish & Ustick, Inc.,

"By Frank H. Wells, Treasurer.

"A. L. Hopkins, Insured."

No copy of the form of this war rider was filed with the Superintendent of Insurance or approved by him prior to the delivery of the policy to Mr. Hopkins. No copy of any form of policy containing the terms, provisions, and conditions of the war rider as a part thereof, was filed with or approved by the Superintendent of Insurance. Nor did the war rider bear the signature of any executive officer of the company. It was simply signed by a corporate agent, "Wells, Potter, Fish & Ustick, Inc." And no approval of said rider by an executive officer of the defendant was indorsed on the policy.

The plaintiff contends that the war rider was invalid, and of no force or effect, by reason of the defendant's failure to comply with the provisions of chapter 155 of the Laws of 1914, in making use of the rider, in that: (1) The defendant failed to file said rider with the Superintendent of Insurance, and have it approved by him, prior to the issuance and delivery of the policy. (2) The rider constituted a change in the policy, and as such it had to have the indorsed approval by an executive officer to validate it under the provisions of the statute, and the policy itself. (3) The rider was not "printed in bold-face type and with greater prominence than any other portion of the text of the policy," and as such there was a clear violation of paragraph (6) of subdivision (b) of section 107.

The trial court has found that the defendant failed to comply with this law in respect to the filing of the war rider, but that this violation did not invalidate the rider. The court also held that the rider did not effect any change in the policy because it was a part of the policy, having been annexed to it at the inception of the policy contract, and that therefore there was no necessity for the approval in writing of an executive officer of the company. There is no doubt that the rider in question was a part of the policy. It is made so by the terms of the policy itself. And there can be no doubt that in issuing this policy without having filed this form of war rider with the Superintendent of Insurance the defendant violated chapter 155 of the Laws of 1913, amending

Insurance Law, § 107, subd. (a) part of which reads as follows:

"(a) On and after the first day of January, nineteen hundred and fourteen, no policy of insurance against loss or damage from the sickness, or the bodily injury or death of the insured by accident shall be issued or delivered to any person in this state by any corporation organized under article two of this chapter, or, if a foreign corporation, authorized to do business in this state, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Superintendent of Insurance."

The purpose of this statute was to carry out the public policy of the state to take control of the forms of insurance contracts and prevent insurance companies from issuing any form of policy not approved by the Superintendent of Insurance. That part of the policy which had been approved by the Superintendent of Insurance clearly covers a loss such as occurred in this case (see part A of the policy). The rider in question here cut down this risk, so as to exclude death by accident caused by any belligerent in the present war. In a very substantial particular it changed the form as approved by the state. The issuance of a policy in this form without the approval of the Superintendent of Insurance under subdivision A, supra, is absolutely forbidden. The trial court held that notwithstanding the law had been violated in issuing the policy, it was nevertheless a valid policy as to all its provisions, including the war rider.

[2] The defendant contends that even if the issuance of an unfiled and unapproved rider or policy be a violation of the act in question, such rider and policy are not thereby invalidated, but on the contrary are validated by subdivision (i) of section 107, which reads as follows:—

"(i) A policy issued in violation of this section shall be held valid but shall be construed as provided in this section and when any provision in such a policy is in conflict with any provision of this section, the rights, duties and obligations of the insurer, the policyholder and the beneficiary shall be governed by the provisions of this section."

We think this contention is unsound. Without doubt, the purpose of this provision is to preserve the policy, but not to the extent of making valid those parts inserted therein without authority of law. Subdivision (i) declares that the policy shall be valid, and then lays down a rule construing the policy and determining the rights, duties and obligations of the parties. The policy must be construed according to the provisions of section 107, and if any provision of the policy is in conflict with the provisions of that section the provisions of the section must control. In the case at bar the war rider is obviously in conflict with subdivision (a) of section 107. It was issued unlawfully, and therefore the only parts of the policy which are valid under sub-

division (i) are those which conform to the provisions of section 107; that is, every part of the policy except the war rider.

[3] The defendant claims that subdivision (i) of section 107 is limited in its application to changes in the standard provisions mentioned in subdivisions (c), (d), and (e) of section 107; but subdivision (i) does not so declare. On the contrary, it expressly refers to *any* provisions in the policy which are in conflict with *any* provision of section 107.

[4] The defendant contends also that the only penalty following a violation of the law of filing is found in subdivision (l) of section 107, which reads as follows:—

"Any company, corporation, association, society or other insurer or any officer or agent thereof, which or who issues or delivers to any person in this state any policy in *willful* violation of the provisions of this section shall be punished by a fine of not more than five hundred dollars for each offense, and the Superintendent of Insurance may revoke the license of any company, corporation, association, society or other insurer of another state or country, or of the agent thereof, which or who *willfully* violates any provision of this section."

And in effect the trial court so held. There is nothing in this subdivision to support that view. Only in case the violation is *willful* does the punishment follow. The real and true interpretation of these subdivisions (i) and (l) is that if the policy is issued in violation of section 107, willfully or not, the illegal part of the policy must be discarded and the legal parts retained in full force, and if the illegal parts have been issued in willful disobedience of the law the party so issuing the policy may be punished under subdivision (l). When the Legislature made it a criminal offense to issue policies in willful violation of section 107, it thereby emphasized the importance which it attached to state control over the issuance of policies of insurance. The assured signed this rider, and if it is claimed that this made the rider legal, it is sufficient to say that the parties by their agreement could not make valid a provision of the policy which did not comply with the law, and which was expressly forbidden by law under important considerations of public policy.

We think, therefore, that the court below erred in dismissing this complaint.

[5] It may appear at first sight that the result of this conclusion is to allow the plaintiff to sue on a contract which neither party intended to make. The answer to this objection is that the company, when it issued the policy, must have known that the rider was issued contrary to law, and that under subdivision (i), supra, notwithstanding the invalid rider, the approved provisions of the policy constituted a good policy. In other words, the company issued its policy with full knowledge that the rider could not be enforced, but that the other valid parts could be enforced. Probably in its haste to issue this policy it took the chance of suc-

ceeding in limiting the scope of its risk by a rider which it knew to be invalid. There is a hernia rider attached to this policy. As to this rider the company complied with the law and with the terms of the policy. Its form had been filed and approved by the Superintendent of Insurance, and it being a change in the original form of the policy, it was signed, as the policy required, by an executive officer of the company.

The course pursued by the company in the case of the hernia rider should have been adopted in respect to the war rider, and, having failed to do so, the company can neither claim the benefit of the war rider, nor reject the valid parts of the policy.

The judgment dismissing the complaint is reversed with costs and judgment directed for the plaintiff with costs. Settle order on notice.

McLaughlin, Scott, and Dowling, JJ., concur.

Clarke, P. J. I dissent, and vote to affirm, for the reasons stated by Mr. Justice Shearn at Trial Term.



SOUTHERN WOODMEN *vs.* DAVIS. (No. 66.)*

(Supreme Court of Arkansas.)

1. INSURANCE—FRATERNAL INSURANCE—PROOF OF DISABILITY—FALSE DIAGNOSIS.

Where a member of a fraternal insurance society furnished proof of disability upon blank forms prescribed by the home office of the society, which proofs tended to show he was permanently and totally disabled, his right to recover was not defeated because his physician erroneously diagnosed his affliction as tuberculosis, while the disease in fact was interstitial nephritis, the cause of the disability being merely incidental, and the fact being the substantial matter.

(For other cases, see Insurance, Cent. Dig. §§ 1963, 1964; Dec. Dig. § 789[1].)

3. INSURANCE—FRATERNAL DISABILITY INSURANCE—OCCUPATION OF INSURED.

The terms of a fraternal insurance society's policy, providing for payment of a benefit upon total disability, do not apply solely to the particular occupation named in the member's application, unless the language thereof is sufficient to constitute the statement regarding his occupation a warranty, not only that the plaintiff is engaged in such work, but will continue so engaged.

(For other cases, see Insurance, Cent. Dig. §§ 1955, 1957-1959; Dec. Dig. § 787.)

Appeal from Circuit Court, Grant County; W. H. Evans, Judge. Action by E. Garner Davis against the Southern Woodmen. From a judgment for plaintiff, defendant appeals. Judgment affirmed.

* Decision rendered, June 19, 1916: 187 S. W. Rep. 638.

N. A. McDaniel, of Benton, for Appellant.
 Thos. E. Toler, of Sheridan, and W. D. Brouse, of Benton, for Appellee.

Ex PARTE WILSON. (Cr. 493.)*

(District Court of Appeal of California. Second District.)

2. INSURANCE—FALSE PROOF OF CLAIM UNDER INSURANCE POLICY—ACCIDENT INSURANCE.

One presenting false proofs in support of a claim upon a policy of accident insurance is not guilty of a public offense, under Pen. Code, §§ 548, 549, which has reference only to false or fraudulent proofs of claim under policies for the insurance of property.

(For other cases, see Insurance, Cent. Dig. § 36; Dec. Dig. § 31.)

Habeas corpus on the petition of Newton Wilson. Writ granted, and petitioner discharged from custody.

Davis & Rush, of Los Angeles, for Petitioner.

Thomas Lee Woolwine, Dist. Atty., and George E. Cryer, Deputy Dist. Atty., both of Los Angeles, for Respondent.

* Decision rendered, May 25, 1916. 158 Pac. Rep. 1050.

CONTINENTAL CASUALTY CO. vs. BOWS.*

(Supreme Court of Florida.)

1. INSURANCE — ACCIDENT INSURANCE — POLICY — CONSTRUCTION.

In an action at law, instituted by the insured against an insurance company upon an accident insurance policy which provides an indemnity in the sum of \$500 "for loss of either hand by complete severance at or above the wrist," the insured is not entitled to recovery under such provision, when the evidence adduced fails to show a complete severance of the hand at or above the wrist, even though it may establish that the small portion of the hand so left was practically of no use or service to the insured.

(For other cases, see Insurance, Cent. Dig. §§ 1312, 1313; Dec. Dig. § 527.)

Ellis, J., dissenting.

Error to Circuit Court, Duval County; Daniel A. Simmons, Judge. Action by Charles H. Bows against the Continental Casualty Company, a corporation. There was a judgment for plaintiff, and defendant brings error. Reversed.

* Decision rendered, June 20, 1916. 72 South. Rep. 278. Syllabus by the Court.

Cockrell & Cockrell, of Jacksonville, and George R. Sanderson, of Chicago, Ill., for Plaintiff in Error.
J. W. Holland, of Jacksonville, for Defendant in Error.

CASUALTY, SURETY AND MISCELLANEOUS.**UNITED STATES CIRCUIT COURT OF APPEALS.**

FIFTH CIRCUIT.

GEORGIA CASUALTY CO.

v.s.

BOWRON. (No. 2844.)*

INSURANCE—INDEMNITY INSURANCE—LIABILITY.

Defendant issued a policy insuring the trustee, carrying on a bankrupt's business, against loss from injuries to employees. The policy declared that no action should lie against defendant under the indemnity clause, unless brought in the name of the insured for loss actually sustained and paid in money by insured in satisfaction of a judgment after trial of the issue. Pending the case of an injured employee against the trustee, the bankrupt's property was sold, the purchaser obligating itself to hold the trustee harmless against any and all liability for damages to persons or property resulting from the carrying on of the business of the bankrupt, and the judgment finally recovered by the injured servant was paid by the vendee of the purchaser, which assumed its obligation. The decree under which the property was sold expressly provided that the sale and conveyance should be subject to the condition that the court might take and resell the property in case the purchaser should fail to pay any part of the purchase price. Held that, as the sale was conditional and as the purchase price was necessarily diminished by the amount of the judgment recovered against the trustee by the injured servant, the trustee suffered a loss for which the insurer was liable.

(For other cases, see Insurance, Cent. Dig. § 1144; Dec. Dig. § 435.)

In error to the District Court of the United States for the Northern District of Alabama; William I. Grubb, Judge.

Action by James Bowron, trustee in bankruptcy of the Southern Iron & Steel Company, against the Georgia Casualty Company. There was a judgment for plaintiff (223 Fed. 673), and defendant brings error. Affirmed.

Before PARDEE and WALKER, C. J., and MAXEY, D. J.

E. H. CABANISS, of Birmingham, Ala., for Plaintiff in Error.
Augustus BENNERS, of Birmingham, Ala., for Defendant in Error.

WALKER, C. J.

This was an action on an employer's liability insurance policy issued to James Bowron as receiver in bankruptcy of the Southern Iron & Steel Company, which, upon his appointment as trustee of the bankrupt's estate, was by indorsement made payable to him as such trustee. After the date of a decree ordering the sale of

* Decision rendered May 8, 1916. 233 Fed. Rep. 89.

the bankrupt's property, but before the sale under that decree, and while the bankrupt's property was in possession of and operated by the trustee, Carl Sibert, an employee of the trustee, sustained personal injuries. Against loss arising or resulting from a claim upon the assured for damages on account of those injuries the insurer, by the policy, undertook to indemnify the assured. A judgment in favor of Sibert was rendered against the assured in a suit brought to recover such damages, the defense of which suit was conducted by the insurer, as provided for in the policy, and that judgment has been paid. But it is contended in behalf of the insurer, the plaintiff in error here, that the payment was not made by the assured, and that the satisfaction of the judgment was so brought about that the accrual of a right of action in favor of the assured on the policy was prevented by the following provision thereof:—

"No action shall lie against the company under the indemnity clause herein unless brought by and in the name of the assured for loss actually sustained and paid in money by the assured in satisfaction of the judgment after trial of the issue."

Emphasis is laid upon the policy being one of indemnity, not against liability, though it is adjudged to exist, but against "loss actually sustained and paid in money by the assured in satisfaction of the judgment after trial of the issue."

The contention urged is based upon the circumstances that the purchaser of the bankrupt's property, in compliance with the requirements of the decree for its sale, obligated itself to hold the trustee "harmless against any and all liability for damages to persons or property resulting from the carrying on of the business of the bankrupt by him, and for all costs and legal expenses incident thereto not paid or discharged from the proceeds of sale," and that the judgment in favor of Sibert was paid by the vendee of such purchaser, which had assumed its obligations, giving its check, payable to the order of the trustee in bankruptcy, for an amount recited in a statement attached to the check to be "in full payment of judgment and costs of court in the suit of" Sibert against the trustee, and by the trustee by indorsement making that check payable to the order of the clerk of the court, who collected the amount and applied it to the satisfaction of the judgment and costs in the Sibert case. The circumstances just mentioned, upon which the plaintiff in error relies, are not the only ones which are to be looked to in determining whether, within the meaning of the above-quoted provision of the policy, the assured did or did not actually sustain a loss in consequence of Sibert's injury, and did or did not in reality satisfy the judgment recovered by Sibert. The decree under which the bankrupt's property was sold expressly provided that the sale and conveyance of it should "be subject to the condition that the court may retake and resell the property in case the purchaser or purchasers or assigns shall fail to pay any part of the purchase price remaining unpaid,

“to comply with any order duly made by this court with respect to the making of any payment which it is herein provided the purchaser or purchasers shall make, or to perform and discharge any contract or liability of the trustee which by the terms of this order the purchaser shall assume.” And a decree, which, with exceptions therein stated, closed the administration of the bankrupt estate, made in the bankruptcy proceeding after Sibert had recovered his judgment against the trustee, but before the affirmance of that judgment by this court, contained the following provision:—

“There is pending against the trustee the matter of the claim of J. Carl Sibert for personal injuries, as against which the trustee holds a policy of the Georgia Life Insurance Company, and also the undertaking of the purchaser of the property of this estate to hold him harmless against the same, which said matter and all things material, pertinent, or incident thereto are excepted, and this proceeding, so far as the same are concerned, is not closed, but remains open until finally disposed of and settled.”

It resulted from the court’s action that the sale of the bankrupt’s property was a conditional one, that the amount of the judgment recovered by Sibert was a part of the purchase price required to be paid, was made a charge on the property in the hands of the purchaser or a subvendee, and that the property remained under the control of the court and subject to administration as assets of the estate in bankruptcy so far as that charge upon it was concerned.

The policy sued on insured to the benefit, not of James Bowron, the individual, but of the bankrupt estate which the court was administering, and which was in his charge as the court’s agent and trustee. It well may be inferred that the net amount realized from that estate was lessened—in other words, that the estate was subjected to a loss—by selling it conditionally and subject to the charge against it of the amount to be recovered as damages for a personal injury that had been sustained before the sale was made, instead of selling it unconditionally and free of any incumbrance. But, aside from that consideration, a vendor who brings about the payment of a demand of a third party against him by making it a charge upon the thing sold, which is worth greatly more than the amount of the demand so provided for, may well be regarded as in reality the payer of that demand, though the money used in making the payment is supplied by the conditional owner of the thing sold, who is practically coerced into making the payment for the vendor to save himself. In such a case it is at last the vendor who supplies the means of bringing about the payment. A result of the orders of the court above referred to and what was done under them was to put the bankrupt estate, represented by the assured, its trustee, in the position of such a vendor. The evidence as a whole was such as to require the conclusion that the bankrupt estate, while it was subject to administration under the

orders of the court by the trustee, to whom the policy was payable, sustained a loss measured by the amount of the judgment recovered by Sibert, and that that judgment in reality was satisfied out of the bankrupt estate while it was still within the court's grasp. A contrary conclusion would be the result of considering only the form which the transaction assumed, and losing sight of the real nature and effect of it. We are of opinion that, as applicable to the evidence, the charge which the court gave was a proper one, and the judgment is affirmed.

Maxey, D. J., was prevented by illness from participating in the decision of this case.

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ST. LOUIS COURT OF APPEALS.

MISSOURI.

DE MUN ESTATE CORP.

vs.

FRANKFORT GENERAL INS. CO. (No. 14195.)*

1. INSURANCE—LANDLORD'S CONTINGENT POLICY—CONSTRUCTION—"OCCUPATION"—"POSSESSION."

Where every part of the habitable portion of the building was let to and occupied by tenants when the cornice of the roof fell and injured pedestrians, the policy, stipulating indemnity for the owner, for sums paid the injured parties, providing that it was issued with the understanding that assured was the owner of the property, but not in occupation or control of it, covered the case, though the owner was in possession of the roof, as "occupation" is not synonymous with "possession," while the language of an insurance policy is to be construed in aid of the insurance rather than to the defeat of it.

(For other cases, see Insurance, Cent. Dig. § 1144; Dec. Dig. § 435.)

(For other definitions, see Words and Phrases, First and Second Series, Occupation; Possession.)

2. INSURANCE—CONSTRUCTION OF POLICY.

A policy of insurance is to be given effect, if permissible, as if it was intended to cover and include the subject of the insurance for which the premium was paid, rather than to aid an escape from liability thereon.

(For other cases, see Insurance, Cent. Dig. §§ 292, 296, 297; Dec. Dig. § 146[1].)

* Decision rendered July 18, 1916. Rehearing denied, July 26, 1916. 187 S. W. Rep. 1124.

4. INSURANCE—LANDLORD'S CONTINGENT POLICY—NEGLIGENCE—SUFFICIENCY OF EVIDENCE.

In an action by the owner of a building against an insurance company for indemnity for amounts paid to persons injured when a cornice of the building fell into the street, evidence held sufficient to support finding that the injuries were caused by the negligence of the insured, and that they were properly chargeable to it by law.

(For other cases, see Insurance, Cent. Dig. § 1722; Dec. Dig. § 665[4].)

5. INSURANCE—LANDLORD'S CONTINGENT POLICY—LIABILITY OF INSURER.

There can be no recovery on a landlord's contingent policy for amounts paid persons injured by the falling of a cornice, unless the cornice was defective when leases of the building were executed by the owner and the property passed into the hands of tenants.

(For other cases, see Insurance, Cent. Dig. § 1144; Dec. Dig. § 435.)

6. INSURANCE—LANDLORD'S CONTINGENT POLICY—OWNERSHIP OF BUILDING.

Where a building was leased by the agent of the heirs of an estate, and thereafter such heirs incorporated, one of them being president and another secretary and treasurer, etc., the company was liable to pedestrians, injured by the falling of a cornice from the building into the street, though the property was under lease when the company acquired it, so that an insurance company, which had insured the heirs against such liability, the name of the assured being changed to that of the company, was liable to it.

(For other cases, see Insurance, Cent. Dig. § 1144; Dec. Dig. § 435.)

Appeal from Circuit Court, Lincoln County; Edgar B. Woolfolk, Judge.

"To be officially published."

Suit by the De Mun Estate Corporation against the Frankfort General Insurance Company. From a judgment for plaintiff, defendant appeals. Judgment affirmed.

Holland, Rutledge & Lashy and Seddon & Holland, all of St. Louis, and Avery, Young, Dudley & Killam, of Troy, for Appellant.

L. L. Leonard, of St. Louis, R. H. Norton, of Troy, and Grover S. C. Sibley, of St. Louis, for Respondent.

NORTONI, J.

This is a suit on a policy of insurance. Plaintiff recovered, and defendant prosecutes the appeal.

The insurance contract is what is known as a "landlord's contingent policy." It vouchsafes indemnity to the owner of the building, who is neither in the occupation nor control of it, for such expenditures as he may make in liquidation of claims arising on account of personal injuries received because of defects in the building or the neglect of the owner which are chargeable to him at law. The building on which the policy covers is situate on the west side of North Sixth street in St. Louis, between Olive and Pine, numbered 207, 209, 211, 213, and 215. It consists of three stories, is constructed of brick, and is known as the Mona Hotel. It is an old building, having been erected about 1843, and was occupied first by De Mun as a residence. About 1855 it was

converted into business property, but during all the time has continued as the property of the De Mun estate; that is, it was owned by the heirs of Isabel De Mun. The policy was originally issued to Julius S. Walsh, agent for himself and the other heirs, on the 20th day of December, 1909, for one year; that is, to December 20, 1910. In the meantime the interests of all of the heirs in the property were incorporated in the name of De Mun Estate Corporation, the plaintiff, and on January 28, 1910, the change of the name of the owner was indorsed on the policy as follows:—

“It is hereby understood and agreed that the name of the assured in this policy is changed to read De Mun Estate Corporation, and ceasing to cover in the name of Julius S. Walsh, agent for himself and other owners as originally written.”

At the time the policy was issued—and indeed, at all times relevant to the questions for consideration here—the building was in possession of tenants. William J. Milford was the lessee, under a lease of date June 29, 1908, for a period of four years, of all of the second and third floors of the building, and also the store-rooms numbered 207, 209 North Sixth street, that is, on the ground floor, in which Milford conducted a hotel, the Mona House, and restaurant. Moreover, it appears Milford had possession of a small basement under the building as well. Joseph Fireside & Co. were the lessees under a lease of date August 12, 1907, for a period of five years, of storerooms numbered 211, 213 North Sixth street on the ground floor, while one Joyce was a tenant and occupied the remaining storeroom, that is, No. 215 North Sixth street, as a dramshop. With the property thus occupied, the policy was issued to the heirs of the De Mun estate, Julius S. Walsh, agent, and continued in force under the change of name after the incorporation of the estate as above indicated.

[1, 2] On a quiet evening in June, 1910, a considerable portion of the cornice on the front of the building fell from position into the street, and injured several pedestrians. Plaintiff expended about \$3,700 in settlement of the claims of persons so injured preferred against it, and sues upon the policy for indemnity. It is argued the subject-matter in suit is not within the terms of the policy, for that plaintiff owner was in possession and control of the roof of the building and the cornice which fell, whereas the policy stipulates indemnity only in those cases where the insured is not in such possession and control. The question thus made is to be determined by a construction of the following provision of the policy:—

“This policy is issued with the understanding that the assured is the owner of the property, but is not in occupation or control of it, the actual occupation or control being vested in a lessee or lessees, and it is hereby agreed that the company shall not be responsible for any loss, excepting such as may be occasioned by some fault or neglect on the part of the assured, or may be charge-

able to him by law, notwithstanding the fact that the property is leased or beyond his control, and this policy is accepted by the assured accordingly."

We regard the argument as more specious than sound, in that it reckons with the words "occupation or control" contained in the policy apart from the entire property as tenements, and seeks to confine them to a mere infinitesimal portion of the subject-matter insured; that is, to the roof, or rather, the cornice, which fell to the ground and injured the several pedestrians. Moreover, the argument proceeds in the view that the word "occupation" is synonymous with the word "possession," which is in no wise true, and as if possession intends, in part at least, a constructive possession which draws to it the right of control touching the cornice. It appears that every part of the building, that is, the habitable portions, was let to and occupied by tenants at the time the policy was issued and throughout the whole period involved here. This being true, no portion of it was in the "occupation or control" of the owner according to the intendment of the policy contract when interpreted under the principle of law relevant to insurance matters. No one can doubt that the language employed in an insurance policy is to be construed in aid of the insurance rather than to the end of defeating it, for, indeed, the insurance vouchsafed is the very object and purpose of the contract. See *Stix vs. Travelers' Indemnity Co.*, 175 Mo. App. 171, 177, 157 S. W. 870. Moreover, the policy is to be given effect, if permissible, as if it was intended to cover and include the subject of the insurance for which the premium was paid, rather than to aid an escape from liability thereon. See *Still vs. Connecticut Fire Ins. Co.*, 185 Mo. App. 550, 172 S. W. 625. The provision above copied proceeds:

"This policy is issued with the understanding that the insured is the owner of the *property*, but is not in occupation or control of *it*, the actual occupation or control being vested in a lessee or lessees." (The italics are our own.)

In so far as these words are concerned they relate to the *property* and not merely to the roof or the cornice. It is certain that this *property*, considered as the subject-matter insured, was not in the occupation or control of the owner, for it was under lease and occupied by the several tenants, and, indeed, the leases stipulate that it was given over to the lessees in its present condition without any obligation on the landlord to make repairs for their benefit. Obviously plaintiff owner did not occupy the roof of the building, nor the cornice, and it cannot be said, in the sense of the policy, that it even controlled them. Whether Milford, who occupied two of the storerooms on the ground floor as a restaurant and the second and third stories of the building as a hotel, is to be regarded in occupation and control of the roof and cornice as appurtenances to his tenement is immaterial under this policy, for it is clear plaintiff was neither in occupation nor control of the *property*, that is, the habitable portions of it, which as a whole

is the subject of the insurance. The concluding words of the provision of the policy above copied, that is, the words "notwithstanding the fact that the *property* is leased or beyond his [the owner's] control," imply too that the stipulation relates to the property as property for the uses intended rather than to a mere isolated portion such as the roof or the cornice, which in no sense is either occupied or controlled at all for the uses of either the tenant or the landlord. In this view the subject-matter in suit, i. e., the payments made to the injured persons, is clearly within the terms of the policy, and it is unnecessary to consider the argument directed against the instruction touching the question as to the occupation or control; for the court should have directed as a matter of law that plaintiff was not in the occupation or control of the cornice which fell, in that all the habitable portions of the property were in the occupation and control of the tenants.

[3, 4] But it is argued that though such be true, it does not sufficiently appear that the damages liquidated by plaintiff were occasioned by some fault or neglect on the part of the assured, or that they are chargeable to it by law according to the purport of the provision of the policy above set forth. There is no question about the fact that the cornice because of its own defects fell into the public street on a quiet evening, when it is said the current of air was not to exceed three miles per hour. It is conceded too that all of the parties to whom the payments were made received injuries from the fall of the cornice without fault on their part while passing the way. Ordinarily the presumption of negligence which attends such a state of facts would alone suffice, in that the rule *res ipsa loquitur* applies. See *McNulty vs. Ludwig*, 125 App. Div. 291, 292, 109 N. Y. Supp. 703. For, as said by the court in *Mullen vs. St. John*, 57 N. Y. 567, 571, 15 Am. Rep. 530, it is similar to the case of a ship thought to be seaworthy which should go to the bottom in a tranquil sea and without collision. The mind in such circumstances necessarily seeks for a cause of the occurrence. Apparently it is the defective condition of the structure. This, of course, leads to the inference of neglect of duty which suffices as a *prima facie* showing and casts the burden to rebut it on defendant. But the presumption is to be put aside here, for that, to cast liability at law upon the owner of the property, there must be some showing that the building was defective at the time possession was given over to the tenants under the leases, and it appears the leases were made about three years before. It appears that the cornice which fell was placed on this old building about twenty-five years before the occurrence. It was constructed by means of placing 2 x 4 pine timbers in the brickwork of the walls above the roof, and these were covered with a metal sheet. The whole was made fast by means of certain iron braces. In the course of all these years the elements had caused this metal sheeting, which constituted the outside and covering of the cornice, to disintegrate, and thus permitted the rain

and snow to reach the wooden supports and iron braces within. The 2 x 4 pine pieces had decayed, and the iron bolts rusted until they broke. The mortar between the brickwork to which the whole was affixed had, through thus being exposed to the elements, lost its bond until it had disintegrated into a mere sandy substance without resisting power. Expert evidence, given by experienced builders and men engaged in the business of wrecking buildings, tended to prove that this condition was of long standing, and it sufficiently appears that it was discoverable by ordinary care for a period of several years before, at least antedating the leases in question. This evidence is abundant as tending to prove that this old, dilapidated, and weatherworn cornice thus overhanging a sidewalk on a public street was a nuisance, for injuries from which the owner of the property was liable even at the time the property was let to the tenants. The finding to the effect that the injuries received by the pedestrians in the street were caused by some fault or neglect on the part of the insured, and that they were properly chargeable to it by law, is amply supported by the evidence. The question concerning this matter was sufficiently submitted to the jury by plaintiff's instruction No. 3 and defendant's instruction No. 7.

[5, 6] But it is argued plaintiff, De Mun Estate Corporation, the insured under the policy as it now stands, is in no view liable at law to the persons injured in the street by the falling of the cornice, for that the property was under lease at the time it acquired it. The leases were made by the De Mun heirs through Julius S. Walsh, agent, one in 1907 and the other in 1908, and plaintiff De Mun Estate Corporation came into being subsequent thereto, that is, late in the year 1909. This argument proceeds in the view that, though the evidence sufficiently shows fault and neglect on the part of the De Mun heirs even prior to the date of the leases, such fault and neglect may not be attributed to plaintiff, De Mun Estate Corporation, which, it is said, succeeded to the property subject to the leases. We put aside entirely the argument that he who knowingly continues a nuisance is responsible as well as his predecessor for permitting it in the first instance, as of doubtful import here because in no view may liability be cast secondarily against defendant insurance company, unless the cornice was defective at the time the leases were executed and the property passed into the hands of the tenants, for that the owner of the property is not to be held for a dereliction of duty thereafter. Be this as it may, however, it is abundantly clear that plaintiff, De Mun Estate Corporation, is, both in spirit and substance, a mere continuation of the prior owner; that is, the several heirs of the De Mun estate. The property was owned by the heirs of Isabel De Mun, and the leases were made by them through their agent, Julius S. Walsh, for himself and the other owners. In the latter part of the year 1909 the estate was incorporated and the property turned over to it as capital, while shares

of stock were issued to each heir, representing his proportionate part of the property. One of the heirs was president, another secretary and treasurer, etc., of the corporation, and it amounts to no more than encasing the estate in a corporate charter, for, as said before, in both spirit and substance the assured and lessor remained the same. In other words, the name of the assured and owner was merely changed, and, indeed, such is recognized as the fact by defendant in the indorsement on the policy to that effect. By the express words of this indorsement it is recited of date January 28, 1910, that "the name of the assured in this policy is changed to read De Mun Estate Corporation." Obviously, though a corporate charter was obtained and as incident thereto a franchise for the property interests of the several heirs to continue and subsist as a corporate entity rather than as individual private rights, the interests of the heirs remained the same throughout, in that the De Mun Estate Corporation represented the same rights of property as did the lessors, the heirs of the De Mun estate, at the time the leases were executed. It is a benign precept that the common law heeds the substance rather than the mere shadow of things. In such circumstances, the plainest principles of natural justice impel that the corporation should be regarded as a mere change of name of the owner. In other words, as is well said in the brief, it is similar to the case of an owner going into court after the lease is executed and before the loss and having his name changed by decree, or a feme sole owner and lessor taking a different name as the name of her husband through marriage. In either event the owner lessor and assured remains the same person. The principle declared in Winkleman vs. Des Moines & Mississippi Levee Dist., 171 Mo. App. 49, 153 S. W. 539, and more recently vindicated in Wilson vs. Drainage District, 257 Mo. 266, 165 S. W. 734; s. c., 176 Mo. App. 470, 158 S. W. 931, is reflected and finds appropriate application here.

We see nothing further in the case that merits discussion in the opinion. All of the arguments advanced for a reversal of the judgment have been duly considered, but we regard them as insubstantial.

The judgment should be affirmed. It is so ordered.
Reynolds, P. J., and Allen, J., concur.

COURT OF CIVIL APPEALS OF TEXAS.

AMARILLO.

GREAT EASTERN CASUALTY CO.

vs.

BOLI. (No. 994.)*

INSURANCE—LARCENCY INSURANCE—PROOF OF THEFT—
“MERE DISAPPEARANCE.”

Within a policy against loss by theft, though providing that mere disappearance of property shall not be deemed sufficient evidence of theft, insured's testimony that on a certain night, according to his custom, he took his diamond stud out of his tie, placed it on the dresser in his room, and the next morning discovered its loss, on search, and that for stated reasons he remembered distinctly such disposition thereof by him, is sufficient evidence to go to the jury; the facts testified to constituting more than “mere disappearance.”

(For other cases, see Insurance, Cent. Dig. §§ 1129, 1135, 1143; Dec. Dig. § 425.)

Appeal from Dallas County Court at Law; T. A. Work, Judge.
Action by L. O. Boli, Jr., against the Great Eastern Casualty Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Saner, Saner, Kimbrough & Turner and Chas. D. Turner, all of Dallas, for Appellant.

Martin A. Seward and O. F. Wencker, both of Dallas, for Appellee.

HENDRICKS, J.

The appellee, Boli, sued the appellant, Casualty Company, in the county court of Dallas County, at law, to recover the sum of \$425, for the value of a diamond stud, alleged to have been stolen, and the loss covered by a policy of insurance, issued by the appellant, protecting the appellee against loss from burglary, theft, or larceny. The jury returned a verdict, finding that the stud in question was stolen and was of the value alleged, upon which judgment was rendered for said sum.

We think appellee's petition sufficiently exhibits an insurable interest in the property at the time of the issuance of the policy and at the time of the loss, and without discussion overrule the assignments based upon exceptions raising that question.

The real question is whether the appellee sufficiently proved, as a jury question, the loss of the diamond within the purview of the clause of the policy. The policy of insurance sued upon provided that the Casualty Company should insure the appellee “against loss from burglary, theft, or larceny,” and clause D of a rider attached thereto provided that:—

* Decision rendered, May 17, 1916. Rehearing denied, June 14, 1916. 187
S. W. Rep. 686.

"Mere disappearance of property shall not be deemed sufficient evidence of burglary, theft, or larceny."

The appellee testified that on Saturday night, May 9, 1914, according to his custom, he took the diamond stud out of his necktie, placed the same on the chiffonier in his room, and the next morning he discovered the loss of the same, upon search. He said he remembered distinctly taking the stud from the tie and examining it under the electric light in his room to see if the prongs were intact, and if the diamond needed cleaning, as he intended to clean the same the next morning, Sunday. The next morning, as he went to place his collar and cuff buttons in his shirt, he noticed that the stud was gone.

Appellant insists that its peremptory instruction, considering the clauses of the policy, should have been given, alleging the insufficiency of the testimony. Appellant cites and copiously quotes from the following New York case, Duschenes vs. National Surety Co., 79 Misc. Rep. 232, 139 N. Y. Supp. 881, as one, among others from the same court, as persuasive of this case in its favor. The case of Duschenes vs. National Surety Co., *supra*, was decided by one of the Supreme Courts of New York, and discloses that the plaintiff occupied rooms in a hotel; that she wore the particular pieces of jewelry alleged to have been stolen the day before the alleged theft, and after placing the jewelry in a plush case deposited the case in a jewelry box on her bureau. The next morning, after returning from breakfast, she found the jewelry missing from the jewelry box. The defendant had insured the plaintiff against "direct" loss "by burglary, theft, or larceny," and the court said, among other things:—

"At most, the plaintiff has submitted evidence which shows that the piece of jewelry has disappeared under circumstances that might perhaps permit an inference that it was stolen."

The particular policy in that case further provided:—

"The assured shall also produce direct and affirmative evidence that the loss of the article or articles for which claim is made was due to the commission of a burglary, theft, or larceny; the disappearance of such article or articles not to be deemed such evidence."

This last provision was particularly stressed as an actuating reason for the denial of plaintiff's cause of action; the court further saying:—

"That the insured must produce, not circumstantial, but direct and affirmative, evidence of the wrong."

The further comment was:—

"Parties may be mistaken in their recollection of where they placed a piece of jewelry, but they are not apt to be mistaken in recollection as to matters directly and affirmatively showing a felony, and the defendant could reasonably provide that there could be no recovery unless, in addition to the testimony of the disappearance of the jewelry, the insured should produce testi-

mony of a direct and affirmative kind that there has been a felony."

The present policy and the one quoted from in the case cited, as will be readily seen, present a marked difference as to the quantum of proof necessary to establish theft, and, unless the clause, "Mere disappearance of property shall not be deemed sufficient evidence," negatives the sufficiency of the proof, we think, upon the evidence, the cause was subject to submission to the jury.

By process of elimination, the New York case, *supra*, could be considered an authority against the contention of appellant. It is noted that the court said:—

"At most, the plaintiff has submitted evidence which shows that the piece of jewelry has disappeared under circumstances that might perhaps permit an inference that it was stolen."

If that be true, the controlling point in that case must have been influenced by the clause requiring that the assured should produce direct and affirmative evidence that the loss of the article was due to the commission of a crime.

We think the clause in this particular policy, that mere disappearance should not be deemed sufficient evidence, is merely the statement of a general legal truth; however, disappearance of the diamond under the conditions stated by appellee, after having been placed upon the chiffonier by him in the evening, and missing therefrom the morning thereafter, would not constitute a "mere disappearance," exempting the insurer from liability. If appellee's testimony is to be believed, and the jury resolved it, the inference is reasonably deducible, as we think the New York court really admitted, that the property disappeared under circumstances exhibiting loss by a criminal act, sufficiently proven as at common law, though in the New York case not sufficiently established, measured by the quantum of proof contracted for in that policy.

The judgment of the trial court is affirmed.



BROWNE *vs.* COMMERCIAL UNION ASSUR. CO. OF LONDON, ENGLAND. (Civ. 1592.)*

(District Court of Appeal, First District, California.)

1. INSURANCE — AGENCY FOR INSURER — AUTHORITY OF AGENT—"WRITTEN."

A letter from insurance company appointing an agent, providing, "Policies will be written at this office," gives the agent no authority to make a contract of insurance, since the word "written" means more than the physical act of filling in the blanks of a policy, insurance "written" being insurance contracted for; and the consummation of an insurance contract through such agent is dependent upon its

* Decision rendered, May 24, 1916. Rehearing denied by Supreme Court, July 20, 1916. 158 Pac. Rep. 765.)

ultimately being written at the company's general offices and delivered to assured.

(For other cases, see Insurance, Cent. Dig. §§ 116, 121; Dec. Dig. § 87.)

2. INSURANCE—AGENCY FOR INSURER—"GENERAL AGENT."

The authority to complete insurance contracts primarily differentiates a general agent having power to bind his principal from mere soliciting agents and other intermediaries operating between the insured and the insurer, who have authority only to initiate contracts, and consequently cannot bind their principals by anything they may say or do during the preliminary negotiations.

(For other cases, see Insurance, Cent. Dig. §§ 117, 118; Dec. Dig. § 88.)

(For other definitions, see Words and Phrases, First and Second Series, General Agent.)

3. INSURANCE—CONTRACT—RIGHT TO REFORMATION.

Where insured, upon being advised by insurer that his automobile policy did not cover loss by direct collision, nevertheless elected to retain it, and neither requested the insurer to issue to him a different policy, nor offered to pay the premium requisite to insure against the additional risk of loss by direct collision, he accepted the policy as complying with his application, and could not have it reformed to cover such loss.

(For other cases, see Insurance, Cent. Dig. § 272; Dec. Dig. § 143[8].)

4. INSURANCE—ESTOPPEL OF INSURER TO DENY COVERAGE CLAIMED.

Where insured, after some debate, selected a rider form to be attached to his automobile policy to cover loss by direct collision, and shortly thereafter, on such loss occurring, was informed by the company that the rider did not cover it, the company by paying the loss because it was small, was not estopped to deny liability for future similar losses.

(For other cases, see Insurance, Cent. Dig. § 1040; Dec. Dig. § 391.)

Appeal from Superior Court, Monterey County; B. V. Sargent, Judge. Action by Maxwell Browne against the Commercial Union Assurance Company of London, England. From a judgment for plaintiff, defendant appeals. Reversed.

Goodfellow, Eells, Moore & Orrick, of San Francisco, and Norris & Warth, of Salinas, for Appellant.

Daugherty & Lacey, of Salinas, for Respondent.



**NATIONAL SURETY CO. vs. FARMERS' STATE BANK
OF SPARKS. (No. 524.)***

(Supreme Court of Georgia.)

4. INSURANCE—FIDELITY BOND—ACTIONS—PLEADING.

Where suit was brought on what was termed a fidelity schedule bond (though it does not appear in the record to have been a sealed instrument), and such bond recited that an employer desired indemnity in respect to certain employees, and continued, "Now, therefore, for and

* Decision rendered, June 12, 1916. 89 S. E. Rep. 581. Syllabus by the Court.

in consideration of a stipulated premium paid or agreed to be paid by the employer," the surety company "hereby covenants and agrees to and with the employer," etc.; and where an agreement to continue the bond in force recited that "in consideration of the payment of the annual premium charge" on a certain named day during each and every year, or within sixty days thereafter, the bond should continue in force for an indefinite term, these recitals imported a consideration; and copies being attached to the petition as amended, a general allegation in the petition, that "in consideration of a certain premium duly paid by the plaintiff to defendant" the latter executed the bond, was not subject to special demurrer.

(For other cases, see *Insurance*, Cent. Dig. § 1584; Dec. Dig. § 629[2].)

Error from Superior Court, Jasper County; J. B. Park, Judge.
Action by the Farmers' State Bank of Sparks against the National Surety Company. Judgment for plaintiff, and defendant brings error. Affirmed, with direction.

Hardeman, Jones, Park & Johnston, of Macon, for Plaintiff in Error.



KANSAS FLOUR MILLS CO. v. AMERICAN SURETY CO. OF NEW YORK. (No. 20289.)*

(Supreme Court of Kansas.)

INSURANCE — CONSTRUCTION — EXTENT OF LIABILITY—WRONGFUL ABSTRACTION—MISAPPLICATION.

A surety bond, indemnifying a principal against loss sustained by "any act or acts of fraud, dishonesty, forgery, theft, embezzlement, wrongful abstraction, or misapplication" on the part of an agent, does not extend to a loss occasioned by a simple mistake of the agent, made without fraud, in paying for merchandise which he had authority to buy.

Appeal from District Court, Sedgwick County.
Action by the Kansas Flour Mills Company against the American Surety Company of New York. From a judgment for defendant, plaintiff appeals. Affirmed.

T. A. Noftzger, George Gardner, and G. W. Cox, all of Wichita, for Appellant.

Stanley, Vermilion, Evans & Carey, of Wichita, for Appellee.

* Decision rendered, July 8, 1916. 158 Pac. Rep. 1118. Syllabus by the Court.



BURKE ET AL. v. MARYLAND CASUALTY CO.*

(Supreme Court of Michigan.)

1. INSURANCE—CASUALTY INSURANCE—ACTION ON BOND—CONCLUSIVENESS OF FORMER JUDGMENT—RELATIONSHIP.

In an action on a casualty bond, indemnifying plaintiff against damages for injury accidentally suffered by its employees while engaged in

* Decision rendered, July 21, 1916. 158 N. W. Rep. 898.

decorating, etc., a judgment against the insured upon a declaration, reciting that the plaintiff therein was an employee of the insured, that it was insured's duty to see that a scaffold and its attachment should be fit and properly adjusted, that the ropes sustaining the scaffold on which plaintiff was working broke by insured's negligence, and threw plaintiff to the ground, defended on the ground that the plaintiff was not an employee of the insured, where the court charged that if the insured had charge of preparing the scaffold and assured the plaintiff that it was safe, they would be warranted in finding the existence of the relation of master and servant, and that plaintiff claimed that the rope had been weakened by use, and that the scaffold fell by the act of the insured in adjusting it so that the rope ground against the wall, did not conclusively establish that the plaintiff was an employee of the assured within the meaning of the policy.

(For other cases, see Insurance, Dec. Dig. 616½.)

**2. INSURANCE—CASUALTY INSURANCE—ACTION ON BOND—
ISSUES—EVIDENCE.**

The defendant casualty company had the right to show, if it could, that when the one who had recovered judgment against the insured was injured he was not an employee of the insured, within the meaning of the policy.

(For other cases, see Insurance, Dec. Dig. § 616½.)

Bird, J., dissenting.

Appeal from Circuit Court, Muskegon County; James E. Sullivan, Judge.

Action by William Burke, William H. Smith, and Nels B. Nelson, copartners, doing business as Burke, Smith & Nelson, against the Maryland Casualty Company. Judgment for plaintiffs, and defendant appeals. Reversed, and new trial ordered.

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, and Brooke, JJ.

Stevens T. Mason, of Detroit, for Appellant.
Turner & Turner, of Muskegon, for Appellees.



AMERICAN SURETY CO. OF NEW YORK vs. CABELL.
(No. 5958.)*

(Supreme Court of Oklahoma.)

**2. INSURANCE—PREMIUMS—SURETY COMPANIES—DEATH OF
PRINCIPAL.**

Upon the death of the principal, an executor's bond, furnished by a surety company, can earn no further premiums.

(For other cases, see Insurance, Cent. Dig. § 391; Dec. Dig. § 181.)

* Decision rendered, July 11, 1916. 159 Pac. Rep. 352. Syllabus by the Court.

Error from District Court, Oklahoma County; W. R. Taylor, Judge. Action by Ellen D. Cabell against the American Surety Company of New York. Judgment for plaintiff, and defendant brings error. Affirmed.

Wilson, Tomerlin & Buckholts, of Oklahoma City, for Plaintiff in Error.

J. V. Cabell, of Monrovia, Cal., for Defendant in Error.

LA TOURETTE vs. McMASTER, STATE INS. COM'R.

(No. 9397.)*

(Supreme Court of South Carolina.)

1. INSURANCE—REGULATION.

Insurance is a business affected with such public interest that it may be regulated by the state under the power to legislate for the common good.

(For other cases, see Insurance, Cent. Dig. § 3; Dec. Dig. § 3.)

Petition for mandamus by Philip La Tourette against Fitzhugh McMaster, as Insurance Commissioner of the State of South Carolina. Petition dismissed.

R. H. Welch and John L. McLaurin, both of Columbia, for Appellant. Thos. H. Peebles, Atty. Gen., and W. H. Townsend, of Columbia, for Respondent.

* Decision rendered, June 27, 1916. 89 S. E. Rep 398.

HOPKINS vs. AMERICAN FIDELITY CO. (No. 13291.)*

(Supreme Court of Washington.)

2. INSURANCE—INDEMNITY POLICY—CONSTRUCTION—INTERFERENCE WITH COMPROMISE.

Statements by an insured under an automobile indemnity policy to a claimant that he was insured and would try to get a settlement with the company for an injury to claimant, and later that a lawyer coming to see the claimant represented the insurance company and not the insured, although he might call himself the insured, did not constitute an "interference with negotiations for compromise," prohibited by the policy.

Department 2. Appeal from Superior Court, King County; Mitchell Gilliam, Judge.

Action by Ralph S. Hopkins against the American Fidelity Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Douglas, Lane & Douglas, of Seattle, for Appellant. C. H. Winders, of Seattle, for Respondent.

* Decision rendered, July 5, 1916. 158 Pac. Rep. 535.

LIFE.**SUPREME COURT OF NEW YORK.
APPELLATE TERM, FIRST DEPARTMENT.****DOSCHER****vs.****VANDERBILT.*****1. INSURANCE—MUTUAL ASSOCIATIONS—CREATION OF CONTRACT.**

Compliance by applicants for membership in a mutual life assurance association with the requirement of its by-laws to pay an initial fee and to sign the by-laws, together with the constitution and by-laws of the association, created a contractual relationship between the association and its members.

(For other cases, see Insurance, Cent. Dig. § 1851; Dec. Dig. § 713.)

2. INSURANCE—PERSONS ENTITLED TO BENEFITS—ASIGNEE.

After the death of a member of a mutual life association who has complied with its constitution and by-laws, an assignee of the member had a good legal right to demand, receive, and sue for the amount contracted to be paid by the association at the death of a member.

(For other cases, see Insurance, Cent. Dig. § 1873, 1875, 1876, 1977-1980; Dec. Dig. § 728.)

3. INSURANCE—ACTIONS—PARTIES.

The assignee of a deceased member of a mutual life association has the election to join in one suit all the members of the association for the agreed benefits, or, as authorized by Code Civ. Proc. § 1919, to sue the president of the association.

(For other cases, see Insurance, Cent. Dig. § 1994; Dec. Dig. § 813.)

4. INSURANCE—CONTRACT—CHANGE OR ANNULMENT.

A valid contract between a member of a mutual life association and the association for a life indemnity could not be abrogated or changed without the consent of the member.

(For other cases, see Insurance, Cent. Dig. § 1869; Dec. Dig. § 725.)

5. INSURANCE—MUTUAL ASSOCIATION—DISSOLUTION.

A resolution, at a meeting of members of a mutual life association, that the benefits of living members are terminated, and that the association be continued only to collect from the members, and distribute to the assignees of deceased members any death benefits that may have accrued and remain unpaid, is not a resolution to dissolve the association, and does not relieve it from liability under a contract with a member who dies subsequently.

(For other cases, see Insurance, Cent. Dig. § 1844; Dec. Dig. § 707.)

* Decision rendered, July 7, 1916. 160 N. Y. Supp. 871.

6. INSURANCE—MUTUAL ASSOCIATION—DISSOLUTION.

That a large number of members of a mutual life association met and passed a resolution to dissolve would not be binding on a large majority of the members, who did not attend and did not consent to the dissolution.

(For other cases, see *Insurance, Cent. Dig.* § 1844; *Dec. Dig.* § 707.)

Appeal from Municipal Court, Borough of Manhattan, Seventh District.

Action by Anna Doscher against Edgar Vanderbilt, as President of the Teachers' Mutual Life Assurance Association. From a judgment for plaintiff for \$540.41, defendant appeals. Affirmed.

Argued March term, 1916, before Lehman, Pendleton, and Whitaker, JJ.

William J. Moran, of New York City, for Appellant.

Appell & Taylor, of New York City (George H. Taylor, Jr., of New York City, of counsel), for Respondent.

WHITAKER, J.

The action is brought under section 1919 of the Code of Civil Procedure against the defendant "as president of the Teachers' Mutual Life Assurance Association." The action is based upon the claim of a joint or several liability of the members of the association to pay the plaintiff the sum of \$500 on account of the death of her sister, who was a member of the association at the time of her death and who had been such a member in good standing for forty-five years; the decedent having made the plaintiff her assignee.

The pleadings were oral. The complaint as it appears in the record is as follows:—

"This is an action on a contract brought by Anna Doscher, the plaintiff, as the beneficiary or assignee designated upon the books and records of the defendant association in the sum of \$500, being the amount of a claimed insurance benefit which accrued to Margaret Doscher and to her beneficiary upon her death, under the constitution and by-laws of the defendant."

The answer was likewise oral, and consisted of a general denial, and the further defense that the association of which the defendant Vanderbilt was alleged to have been president had dissolved and gone out of existence.

The plaintiff is a sister of the late Margaret Doscher, who died April 26, 1915. Deceased joined the association when it was formed. The object and purpose of the so-called insurance plan of the association are stated as follows in its constitution:—

"We whose names are undersigned, desiring to organize and maintain the Teachers' Mutual Life Assurance Association, whose object shall be to give to each and every member of the same the opportunity to leave at death to a properly designated assignee a sum hereinafter to be named, do hereby agree to the following constitution for said association."

Article 1 of the by-laws prescribes the qualifications of members and provides that:—

"Any teacher in good health employed in a day school * * * desiring to become a member shall apply to * * * or secretary, who shall cause such applicant to sign the constitution and pay an application fee of fifty cents. * * *"

Article 2 provides as follows:—

"Members must make all proper provision to meet the prompt payment of assessments as they are levied."

Articles 3, 4, and 7 provide as follows:—

"Article 3. *Forfeiture of Membership.* If any member shall omit to pay any assessment within fifteen days after payment is requested by the collector, such collector shall send a second request by registered letter, with a copy of articles 11 and 111 of the by-laws inclosed. Within three days after the return of the letter, or the receipt for its delivery, if assessment, together with a penalty of ten cents to pay for postage of second notice, be not paid, then the membership of such person shall be forfeited, and the department collector shall notify the ward collector of the fact and date of forfeiture, and the ward collector shall give a like notice to the financial secretary who shall promptly notify the former member of the fact and date of such forfeiture.

"Any person whose membership has been forfeited or who shall have resigned may be again admitted as a member by the financial secretary upon paying all the assessments such person would have been liable to pay if the previous membership had not been forfeited. Every application for readmission must be accompanied by the usual health certificate or a doctor's certificate.

"Article 4. *Assessments.* Upon receiving from the treasurer notice of the decease of a member, the financial secretary shall notify each ward collector of such death and of the levy of an assessment of fifty (50) cents to be collected from each surviving member of the several department collectors.

"The money in excess of five hundred dollars (\$500) shall be allowed to accumulate and whenever it shall amount to one thousand and twenty dollars (\$1,020) there shall be no call for assessment on the occurrence of a death."

"Article 7. *Payments to Assignees.* Upon application the sum of five hundred dollars (\$500) shall be paid to the assignee of a deceased member except when death shall have occurred during the vacation—in which case the payment shall be made immediately after the reopening of the schools. In case of the death of a member who is indebted to the association for assessments as provided in article 1 of the constitution the amount of such indebtedness shall be deducted from the amount to be paid to the assignee."

It is unnecessary to refer to the other portions of the by-laws.

It is sufficient to state that they show a complete system for the government and regulation of the association.

The directors, it seems, being of the opinion that the plan and system of conducting the association was not financially sound, and that the number of members was not increasing sufficiently to insure the continued success of the association, called a special meeting of the association for January 30, 1915. In the notices of the meeting, insurance was offered to the members in a standard life insurance company in which all the members might become insured by complying with certain conditions. The notice stated that:—

"The benefits of the present Teachers' Life Assurance Association will lapse and become ineffective on or before a date set by the directors."

At the meeting held pursuant to this notice the following resolutions were passed:—

"Whereas, it is the judgment of our officers and managers that this association is not upon a safe, sound, and enduring basis as respects its benefit or insurance features, and that to secure to the surviving members thereof and to those who may hereafter join this organization certain definite insurance benefits that this organization be reorganized and that the members concur therein; and,

"Whereas, with respect to such insurance, it is the judgment of all that this organization be reorganized into a group of insured having relations with the Travelers' Insurance Company:—

"Now, therefore, be it resolved, a quorum of the board of managers of this organization being present and concurring therein, that the benefits of all living members in this organization be and they hereby are terminated, and are hereby declared to have lapsed and become ineffective as of this 30th day of January, 1915; and it is further

"Resolved, that this association be continued only for the purpose of collecting from the members and distributing to the assigns of deceased members any death benefits that may have accrued and remain unpaid. * * *

It was further resolved that no ward collector shall dismiss from membership any member whose name was on the roll December 1, 1914. The following resolution was also adopted:—

"Resolved, that a special committee of three members, to be appointed by the president, be selected to act with the regular auditing committee, and that such combined committee be instructed to audit the accounts of all fiscal officers and agents of this association, and that they report thereon to the president with all convenient speed, and as soon as possible after all claims for accrued death benefits shall have been satisfactorily adjusted, and that if such accounts be found correct, and the balance, if any in the hands of any of them be turned over and paid in the man-

ner prescribed by said combined committee, that when so paid, or such accounts be found to be correct, that thereupon each such officer or agent be and he is hereby released and discharged from any and all liability or duty to this association or any member thereof."

There are two questions to be determined in order to establish the right of the plaintiff to sustain the judgment she has recovered. The first question is, of course, as to whether or not there was a mutual contract between the plaintiff's assignor and the association.

[1] Article 1 of the by-laws requires all applicants for membership before admission to pay an initiation fee and to sign the by-laws. Compliance with this requirement by the members created a contractual relationship between them and there is no doubt that there was a valid binding contract between the plaintiff, the association and every member thereof. The constitution and by-laws constituted such a contract. *Hannes vs. Nederland, etc., Fund*, 152 App. Div. 140, 136 N. Y. Supp. 742; *Ayers vs. Grand Lodge, etc.*, 188 N. Y. 280, 80 N. E. 1020. The substantial and inducing clause of this contract required the association to pay to a member's assignee (providing such member kept her part of the contract; that is, complied with the by-laws) the sum of \$500 upon her death.

[2] After the death of Margaret Doscher, the plaintiff, being her assignee, had a good legal right to demand, receive, and sue for said sum of \$500. Under the by-laws there was an express agreement, each member with all the others, that each would pay a sum sufficient in the aggregate to pay to the assignee of a deceased member his or her proportionate share of the total sum of \$500. Each member was legally liable in at least such an amount. *Gray vs. Haviland*, 42 App. Div. 626, 58 N. Y. Supp. 1060; *McDonald vs. Mutual Benefit Ass'n*, 29 Hun 87.

[3] The plaintiff had her election to join in one suit all the members of the association, or to invoke section 1919 of the Code of Civil Procedure and sue the defendant Vanderbilt as president. I think, therefore, the first question must be answered in the affirmative.

The second question to be determined is: Did the association actually dissolve; and, if so, had it the legal right to dissolve in the manner alleged, and could it legally repudiate all liability to the plaintiff?

[4] There being a valid contract between the plaintiff and the defendant association, the contract could not be abrogated or changed without the consent of the plaintiff. The authorities are uniform that no action on the part of the association without the consent of the plaintiff, which would impair the obligation of the contract or injuriously affect the rights of the plaintiff thereunder would be valid, as was stated by Judge Vann in *Ayres vs.*

Order of United Workmen, 188 N. Y. 280, 80 N. E. 1020, where the defendant sought by change of the by-laws to restrict the character of the business or employment in which the members should be allowed to engage:—

"An amendment of by-laws which form part of a contract is an amendment of the contract itself and when such a power is reserved in general terms the parties do not mean, as the courts hold, that the contract is subject to change in any essential particular at the election of the one in whose favor the reservation is made. It would be not reasonable, and hence not within their contemplation, at least in the absence of stipulations clearly specifying the subjects to be affected, that one party should have the right to make a radical change in the contract, or one that would reduce its pecuniary value to the other. A contract which authorizes one party to change it in any respect that he chooses would in effect be binding upon the other party only, and would leave him at the mercy of the former, and we have said that human language is not strong enough to place a person in that situation."

If the defendant could not make a substantial change in its contract with plaintiff without plaintiff's consent, it can hardly be said that it could abrogate and repudiate the contract arbitrarily. The defendant's attorney claims that plaintiff—"had no vested right to have the old association maintained forever in the form in which it existed before the dissolution."

The answer to that contention is that the extent of the obligation assumed by a person to a contract, in the absence of fraud, will furnish no ground for its repudiation or abrogation in a court of law; and while it is true that plaintiff had no right to insist upon the continuation of the association "forever," she did have the right to insist upon the performance of its contract with her. It is true that, while the by-laws contemplate the right of the members to resign, they do not authorize a part of the members, even though it be a large number of them, to change the character of the reorganization, form a new organization, and repudiate the contract with plaintiff.

[5, 6] An examination of the minutes of the meeting shows that, as matter of fact, there was no resolution passed to "dissolve." In fact the organization was to continue under different plans. The "organization" was to be "reorganized" with the "concurrence" of the members, and it was expressly resolved that no member should be dismissed from "membership whose name was on the roll December 1, 1914." The only part of the resolutions passed which would indicate that the members at the meeting intended to "dissolve" is as follows:—

"Resolved, that this association be continued only for the purpose of collecting from the members and distributing to the

assigns of deceased members any death benefits that may have accrued and remain unpaid."

This resolution, read in connection with the other portions of the minutes of the meeting, indicate that the organization was not "dissolved," but reorganized, and its members turned over to "the Travelers' Insurance Company." But, even had a large number met and passed a resolution to "dissolve," this would not have been binding on the large majority of the members, who did not attend and who did not consent. The number of members was 1,300 or over, and the number attending the meeting about 300; and the notice of the meeting did not contain an express notice that the question of dissolution would be brought before the meeting for action thereon.

It appears by the record that the association now has property which it refuses to apply towards the payment of plaintiff's claim. This action, therefore, is, I think, perfectly proper at this time for the purpose of reaching that property. The judgment does not bind the individual property of the defendant Vanderbilt, nor the individual property of the members of the association, and there must be a subsequent proceeding brought, in the event that the judgment cannot be satisfied from the property of the association. See Code of Civil Procedure, §§ 1921, 1922; McCabe vs. Goodfellow, 133 N. Y. 90, 30 N. E. 728, 17 L. R. A. 204.

The judgment should be affirmed, with \$25 costs. All concur.



**SURROGATE'S COURT OF NEW YORK.
KINGS COUNTY.**

IN RE GEBERT.*

**1. INSURANCE—MUTUAL BENEFIT INSURANCE—RIGHT OF
BENEFICIARY.**

In the absence of any provision on the subject in the laws of a mutual benefit society, the beneficiary named in a certificate issued, to a member has no vested interest in the same which may under certain circumstances become payable on the death of the member.

(For other cases, see Insurance, Cent. Dig. § 1949; Dec. Dig. § 783.)

2. INSURANCE—LIFE POLICIES—RIGHTS OF BENEFICIARY.

In the strict contract of life insurance, the beneficiary takes a vested contractual interest in the fund assured.

(For other cases, see Insurance, Cent. Dig. § 1470; Dec. Dig. § 586.)

* Decision rendered, May, 1916. 160 N. Y. Supp. 782.

In the matter of the judicial settlement of the account of Anna M. Gebert as administratrix of John Jacob Gebert, deceased. Account settled.

Charles Oehler, of Brooklyn, for Accountant.
John Gerdes, of New York City, for Objectants.

KETCHAM, S.

[1, 2] "By the weight of authority, in the absence of any provision on the subject in the laws of the society or in the certificate of insurance, the beneficiary in a mutual benefit certificate has no vested right therein during the lifetime of the member, and his contingent interest therein expires on his death; hence, if he predeceased the member, neither his personal representatives nor next of kin nor his legatees become entitled to benefits on the member's subsequent decease." 29 Cyc. 157, and cases cited from various jurisdictions. Additional authorities to the same effect are to be found in the following treatises: Niblack, Accident Ins. & Ben. Soc. § 202; 1 Bacon, Ben. Soc. & Life Ins. § 243 et seq.

The rule contained in the foregoing quotation must be regarded as settled, though it has not been reached without judicial uncertainty and strife. In the strict contract of life insurance, not involving the features of membership in the underwriting body, the beneficiary takes a vested contractual interest in the fund assured. This is held to be a chose in action, of which the assured cannot be divested without his consent. The occasional rulings that the beneficiary of a membership insurance takes a vested right in the contract may, perhaps, have followed the decisions which were confined to the case of a pure policy of life insurance, and may have proceeded without due thought of the distinction between the two classes of insurance contracts.

This distinction is defined and elaborated by Judge Werner in Shipman vs. Protected Home Circle, 174 N. Y. 398, 407, 67 N. E. 83, 86 (63 L. R. A. 347). His observations make it plain, not only for the purposes to which they were immediately applied, but for the solution of the present dispute, that under the contract effected between a membership corporation and its member, by which a person is appointed as the beneficiary of insurance, to be paid by the corporation, "the appointee has no vested interest in the sum which might, in a contingency, become payable on death of the member."

The account, so far as it fails to charge the administratrix with the sum received from the society which insured the life of the decedent, is approved. The decree will embody this result, together with the dispositions made upon the trial.

Decreed accordingly.

**SURROGATE'S COURT OF NEW YORK.
BRONX COUNTY.**

IN RE SHANLEY.*

1. INSURANCE—LIFE POLICIES—RIGHT TO.

Where an industrial life policy, providing for payment either to the executor, administrator, husband or wife, or any blood relative of the insured, named insured's first wife as beneficiary and after her death the designation was not changed, the second wife, who became administratrix and received payment, cannot claim the proceeds as her own.

(For other cases, see Insurance, Cent. Dig. § 1469; Dec. Dig. § 587.)

2. INSURANCE—LIFE INSURANCE—PAYMENT.

Insured's second wife, not being entitled under the policy to the proceeds, cannot claim them by reason of the payment.

(For other cases, see Insurance, Cent. Dig. §§ 1461, 1464, 1468; Dec. Dig. § 585[1].)

In the matter of the judicial settlement of the account of Bertha Shanley, as administratrix of John Shanley, deceased. Account surcharged, and distribution ordered.

James A. Sullivan, of New York City, for Petitioner.
Felix A. Muldoon, of New York City, for Respondent.
John A. McEveety, of New York City, Special Guardian.

SCHULZ, S.

The widow of the decedent, being also the administratrix of his goods, chattels, and credits, filed her account and prayed for its judicial settlement. The decedent left him surviving two children of full age, the issue of a former marriage, and one child, an infant, the son of the decedent and the accounting administratrix. The accountant charges herself with having received no property of the decedent of any kind.

One of the adult children of the decedent filed objections, in which he claims that the administratrix has failed to charge herself with the sum of \$600, forming a part of decedent's estate which she received, and he also objects to an item in schedule C of said account in the sum of \$191.60 paid for funeral expenses, and to two expenditures, one for medical treatment in the sum of \$42, and one for nursing in the sum of \$40, which, it is alleged, appear in schedule G of the account, and for which no vouchers were filed. No item of \$42 appears in schedule G of the account, and upon the hearing the objections to this alleged item and to the item of \$40 were withdrawn.

[1] It appears that the administratrix has received the sum of \$600, which was the amount due upon an industrial life insurance policy originally in the sum of \$500. The policy is in the usual

* Decision rendered, May, 1916. 160 N. Y. Supp. 733.

form, and provides for payment "to one of the persons described in condition first." Condition "first" provides that the company may pay "to either the executor or administrator, husband or wife, or any relative by blood, or lawful beneficiary, of the insured. * * *" The decedent procured this policy at the time that his first wife was still living, and in the application for the same, which he signed, the name of the beneficiary, "subject to provisions of policy applied for," was given as "Kate Shanley, Wife." The accounting administratrix urges that by virtue of the application in question the policy was payable to the wife of the decedent, and as she was the wife of the decedent at the time of the latter's death she became the beneficiary under the policy.

In this she is in error. There was no new designation of the beneficiary, after the issuance of the policy and the death of the decedent's first wife, Kate Shanley. At the time the application was made and the policy issued, the accountant was not the wife of the deceased, and while he used the term "wife" in the application and the application formed a part of the contract of insurance (*Wachtel vs. Harrison*, 84 Misc. Rep. 76, 145 N. Y. Supp. 982), it clearly appears, from the fact that he inserted the name of the person who was his wife when the application was made, that he intended the beneficiary to be the latter and not the accountant who occupied that relationship at the time of his death (*Day vs. Case*, 43 Hun, 179).

[2] The insurance company did in fact pay the death benefit to the accountant. The accountant sets forth that the check was delivered to her as administratrix. The fact that the company may pay the death benefit to one of several persons does not make the moneys paid under the policy the property of the person to whom the company may elect to pay the same. The provision for such payment is only for the protection of the insurance company, but does not "grant or take away a cause of action from any person." *Wachtel vs. Harrison*, supra; *Ruoff vs. John Hancock Mutual Life Ins. Co.*, 86 App. Div. 447, 83 N. Y. Supp. 758. It cannot by electing to pay any one of the persons mentioned in condition "first," in my opinion, invest that person with the absolute ownership of the moneys paid. If the contrary were the fact, then it would have the power to make any person the beneficiary who would come under the designation quoted above, to the exclusion of the others, and thus a surviving husband or wife would be entirely deprived of any part thereof if payment were made to a relative by blood. *Wokal vs. Belsky*, 53 App. Div. 167, 65 N. Y. Supp. 815.

Upon the death of Kate Shanley, her right to the death benefit ceased and passed to her husband. *Bradshaw vs. Mutual Life Ins. Co.*, 187 N. Y. 347, 80 N. E. 203, 10 Ann. Cas. 266. Upon the latter's death it became a part of his estate (*Olmsted vs. Keyes*, 85 N. Y. 593; *Walsh vs. Mutual Life Ins. Co.*, 133 N. Y. 408, 31 N. E. 228, 28 Am. St. Rep. 651; *Waldheim vs. John Han-*

cock Mutual Life Ins. Co., 8 Misc. Rep. 506, 28 N. Y. Supp. 766), and as the accountant came into possession thereof and is his administratrix she should account for it as such (Ruoff vs. John Hancock Mutual Life Ins. Co., *supra*). The objection to her failure to include this item in her account must therefore be sustained.

[3] As to the second objection, it appears that the decedent was a member of an association of pipe fitters. As such, a death benefit accrued upon his death. The constitution of the association in question provides that, upon the death of a member in good standing, the sum of \$200 is to be paid to those defraying the expenses of the funeral; it further provides that the overplus, if any, shall be paid to either the widow, eldest child, mother, or father of the deceased. The accountant received this death benefit of \$200 and paid the funeral expenses. She now claims that she is entitled to keep the death benefit thus paid to her and to charge the estate with the amount of the funeral expenses. In this she is also in error. The section is very clear and explicit, and the charge against the estate for the funeral expenses was not justified, unless the estate was also credited with the amount of the death benefit. Under these circumstances, the objection to the item in schedule C must be sustained.

[4] Unfortunately, the estate in question is at best very small indeed, and the condition of the accountant, who is left with an infant child dependent upon her, is one which strongly appeals to the equitable consideration of this court. It appears that she did not set aside the exemption to which she was entitled under section 2670, subdivision 4, of the Code of Civil Procedure, and no credit is claimed therefor in her account. In his memorandum submitted on this application, counsel now asks that such allowance be made. She was clearly entitled to such an exemption, the court has the power to award it to her (Code Civ. Proc. § 2735), and in view of the hardship under which she is laboring, in my opinion, should do so.

[5] I am satisfied that the failure of the widow to account for the proceeds of the policy of life insurance was due to an honest and very natural mistake. On the accounting a deficit was shown, and no claim for commissions and expenses of administration was made. As the account will now show a balance by reason of the surcharge, commissions and the expenses of the accounting will be allowed, unless waived.

The following disposition will therefore be made of the matter: The widow will be allowed an exemption of \$150. The accounting administratrix will be credited with the item of \$40, as to which the objection was withdrawn, and she will be surcharged with the sum of \$600, the amount received by her from the insurance company. The item of expenses for the funeral bill, amounting to \$191.60, in schedule C, will be disallowed. The balance remaining after the deduction of commissions and the ex-

penses of the accounting will be distributed to those entitled thereto by law.

Decreed accordingly.



SUPREME COURT OF PENNSYLVANIA.

OPLINGER

vs.

NEW YORK LIFE INS. CO.*

1. INSURANCE—ACTIONS ON POLICIES—INSTRUCTIONS.

In an action on a life policy, instructions on the defense of false statements in the application that if the insured, before his application, suffered from ailments of whose character he would surely be cognizant, the verdict must be for defendant, but that if he suffered from other ailments such that he might have had without being aware of, the good faith of his answers would depend on his knowledge, were not erroneous.

(For other cases, see Insurance, Cent. Dig. §§ 1774-1776; Dec. Dig. § 669[6].)

2. INSURANCE—CANCELLATION—RIGHT OF INSURER.

After the death of the insured, the insurer could not change the status of the beneficiary by rescission of the policy.

(For other cases, see Insurance, Cent. Dig. §§ 534-536; Dec. Dig. § 247.)

Appeal from Court of Common Pleas, Northampton County.

Action of assumpstis by Emma J. Oplinger against the New York Life Insurance Company, on a policy of life insurance. From a judgment for plaintiff for \$5,376.66, defendant appeals. Affirmed.

Argued before Brown, C. J., and Stewart, Moschzisker, Frazer, and Walling, JJ.

Edward J. Fox, of Easton, James H. McIntosh, of New York City, and James W. Fox, of Easton, for Appellant.

Calvin F. Smith and Thomas D. Danner, both of Easton, for Appellee.

MOSCHZISKER, J.

On February 24, 1913, the defendant company issued a policy of insurance on the life of Allen A. Oplinger, naming Emma J. Oplinger, his wife, as beneficiary. An authorized medical examiner of the insurance company certified that Mr. Oplinger was free from all ailments at the time of his examination. In March, 1913, the insured had an attack of influenza; later, as a result of

* Decision rendered, April 17, 1916. 98 Atl. Rep. 568.

overexertion, he suffered a chill, and subsequently developed bronchitis, heart trouble, and Bright's disease; he died in January, 1914. January 22, 1914, the defendant company notified the beneficiary that it rescinded the contract of insurance, on the grounds of fraudulent misrepresentations and concealment of material facts by the insured; at the same time it tendered a return of the premiums, amounting to \$230.01, which tender was refused. Suit was then brought by Mrs. Oplinger; the defendant averred its rescission of the contract, and paid the \$230.01 into court. The verdict favored the plaintiff, judgment was entered thereon, and the defendant has appealed.

[1] The application for insurance showed that Mr. Oplinger was asked whether he had ever had any disease of the heart, lungs, stomach, intestines, liver, kidneys, or bladder, to which he replied, "No"; that he was requested to give the names and addresses of physicians consulted by him, and gave none; further, that he was interrogated as to whether he had consulted any physician for any illness or ailment not mentioned in the application, and replied in the negative. The testimony as to the verity of these answers, and the good faith of Mr. Oplinger in making them, was conflicting. In submitting the issues arising out of this conflict, the trial judge instructed the jury that the evidence, pro and con, was for them to consider and pass upon; that if the insured, prior to his application to the defendant company, suffered from certain designated ailments, of whose character one would surely be cognizant, then the verdict must be for the defendant; but that if he suffered from certain other ailments, of a kind one might have without being aware of the fact, then the good faith of his answers would depend upon the applicant's knowledge. For instance, on the latter phase of the case, the court said:—

"Did he have this heart trouble prior to the time the application was signed; did he know that he had it, and did he sign falsely? If you believe that, then your verdict should be for the defendant. Did he have the heart trouble prior to the signing of the application, and when he signed didn't know he had it, and acted honestly in putting his answers in the application? In that case, even if he did have it, your verdict would be in favor of the plaintiff."

The policy expressly provides that "all statements made by the insured shall, in the absence of fraud, be deemed representations and not warranties," and the trial judge's instructions, above outlined, accord with the law as recently laid down by us in *Suravitz vs. Prudential Insurance Co.*, 244 Pa. 582, 588, 91 Atl. 495, L. R. A. 1915A, 273.

[2] As to the effect of the alleged rescission of the contract the trial judge ruled:—

"If this rescission had been dated the 22d day of January, 1913, instead of 1914, and Allen Oplinger had still been living * * * a different question would be presented, and it would be my duty to charge you, in the line of some of the authorities which have

been cited to me by the learned counsel for the defendant, as to the effect of a rescission; but, * * * Mr. Oplinger being dead, the case must be tried by us just as if there had not been this formal rescission, and as if they (the insurance company) were defending * * * in the first instance, on the ground of fraudulent representations and concealments by Allen Oplinger."

We see no error in the legal attitude thus assumed by the court below. After the death of the insured, the defendant company could not change the status of the beneficiary by an attempted rescission of the insurance contract.

[3] Testimony of declarations by Mr. Oplinger concerning his state of health, made after the policy was issued, was properly excluded under our rulings upon that subject in *Hermány et al. vs. Fidelity Mutual Life Ass'n*, 151 Pa. 17, 18, 24, 24 Atl. 1064. See, also, *Arnold vs. Metropolitan Life Insurance Co.*, 20 Pa. Super. Ct. 61, 68. The attempted distinction between the contract of insurance in the cases just cited and the one at bar, on the ground that the latter permits a change in the beneficiary, loses all force upon an examination of the policy in the *Hermány Case*, which also provides that the "member may change the beneficiary." No matter what the law may be in other jurisdictions, it is established with us that the declarations of an insured, made after the policy has gone into force, cannot be received in evidence to affect the rights of the designated beneficiary, in a suit by the latter to enforce the contract of insurance.

We see no merit in any of the assignments; all of those pressed at the oral argument and dealt with in the appellant's brief have been touched upon, and the others call for no special discussion.

The judgment of the court below is affirmed.



FREITAS vs. FREITAS ET AL. (Civ. 1754.)*

(District Court of Appeal, First District, California.)

2. INSURANCE—MUTUAL BENEFIT—CHANGE OF BENEFICIARIES—RIGHTS OF PREVIOUS BENEFICIARY.

A complaint, alleging that deceased, pursuant to an antenuptial agreement, made plaintiff his beneficiary in an insurance policy, but later substituted his children as beneficiaries, states a cause of action against the children in action to determine conflicting claims.

(For other cases, see *Insurance*, Cent. Dig. § 1948; Dec. Dig. § 782.)

Appeal from Superior Court, Alameda County; Wm. H. Waste, Judge. Action by Louisa R. Freitas against M. F. Freitas, Jr., and others. Judgment for plaintiff, and certain defendants appeal. Affirmed.

* Decision rendered, June 28, 1916. Rehearing denied by Supreme Court, Aug. 25, 1916.

Louis B. Diavila, of Oakland (Jos. P. Lucey, of San Francisco, of counsel), for Appellants.
Rose & Silverstein, of Oakland, for Respondent.

GARRETT vs. GARRETT ET AL. (Civ. 2078.)*

(District Court of Appeal, Second District, California.)

5. INSURANCE—COMPANIES—BY-LAWS—WHAT LAW GOVERNS.

In the absence of a showing to the contrary, it is presumed that the right of an insurance company located in another state to make by-laws is governed by the laws of that state, with which, as provided in Civ. Code, § 301, they must not be inconsistent.

(For other cases, see Insurance, Cent. Dig. §§ 173-175, 293, 1934; Dec. Dig. § 712.)

6. INSURANCE—COMPANIES—BY-LAWS—VALIDITY.

Under Code Iowa, § 1789, providing that the beneficiary named in a certificate may be changed at any time at the pleasure of the assured as may be provided for in the articles or by-laws, a by-law requiring consent of the association to a change of beneficiary is invalid.

(For other cases, see Insurance, Cent. Dig. § 1947; Dec. Dig. § 781.)

7. INSURANCE—CHANGE OF BENEFICIARY—SUFFICIENCY.

Where the by-laws of an insurance company authorize any member to change the beneficiary by indorsement on the certificate of membership, and require a copy of the indorsement signed by the member to be filed with the association, though the member failed to present a copy of the indorsement, a presentation of the original certificate with the indorsement is equally effective, especially where the company in returning the certificate stated that copies had been made, thus waiving the requirement.

(For other cases, see Insurance, Cent. Dig. §§ 1950-1952; Dec. Dig. § 784[1].)

8. INSURANCE—CHANGE OF BENEFICIARY—SUFFICIENCY.

Where insured had the right at his pleasure to change the beneficiary, and had done all in his power to change the beneficiary, and notice thereof was brought home to the insurer before his death, there was an effectual change, under the rule that equity regards that as done which ought to have been done.

(For other cases, see Insurance, Cent. Dig. §§ 1950-1952; Dec. Dig. § 784[1].)

Appeal from Superior Court, Los Angeles County; Louis W. Myers, Judge.

Action by the Bankers' Life Company against Iva L. Garrett and William Edward Garrett, a minor, cross-defendants. From a judgment for cross-defendant William Edward Garrett, cross-defendant Iva L. Garrett appeals. Reversed, with instructions.

* Decision rendered, July 29, 1916. Rehearing denied by Supreme Court, Sept. 25, 1916. 159 Pac. Rep. 1050.

Robert L. Hubbard, of Los Angeles, for Appellant.
 Charles S. Peery, of San Francisco, and William Ellis Lady, of Los Angeles, for Respondent.

SECURITY LIFE INS. CO. OF AMERICA vs. BOOMS ET AL.
 (Civ. 1462.)*

(District Court of Appeal, Second District, California.)

3. INSURANCE—REPRESENTATIONS—RISK—HEALTH.

An applicant for life insurance is bound to disclose such changes in his physical condition as occur pending the negotiation as would influence the insurer's judgment as to the advisability of accepting the risk.

(For other cases, see Insurance, Cent. Dig. § 681; Dec. Dig. § 291[1].)

4. INSURANCE—REPRESENTATIONS—SICKNESS—PENDING DELIVERY OF POLICY.

Civ. Code, § 2577, declares the completion of a contract of insurance to be the time to which a representation must be presumed to refer. An application for life insurance declared that the policy should not take effect until the premium was paid and the policy delivered. The insured in her application stated that she had not any of the diseases mentioned or any illness other than as specifically stated by her. She was attacked by typhoid fever after making the application and before delivery of the policy. *Held*, that on such delivery, in the absence of insured's knowledge of her sickness, the policy was properly rescinded.

(For other cases, see Insurance, Cent. Dig. § 681; Dec. Dig. § 291[1].)

Appeal from Superior Court, Orange County; W. H. Thomas, Judge. Action by the Security Life Insurance Company of America against Lena M. Scott Booms and others, with cross-complaint by defendant Booms. Judgment that plaintiff take nothing on its complaint and judgment for defendant on the cross-complaint, and plaintiff appeals. Reversed.

C. R. Allen, of Los Angeles, and B. E. Tarver, of Santa Ana, for Appellant.

Head & Marks, of Fullerton, for Respondents.

* Decision rendered, July 22, 1916. 159 Pac. Rep. 1000.



NATIONAL LIFE INS. CO. vs. JACKSON. (No. 7281.)*
 (Court of Appeals of Georgia.)

1. INSURANCE—NOTICE AND PROOF OF LOSS—WAIVER—DENIAL OF LIABILITY.

While every insurer has the right to prescribe regulations as to notice and preliminary proof of loss, which must be substantially complied with

* Decision rendered, July 29, 1916. 89 S. E. Rep. 633. Syllabus by the Court.

by the insured, an absolute refusal by the insurer to pay the loss waives a compliance with these preliminaries. Civ. Code 1910, § 2490; *Harp vs. Fireman's Fund Insurance Co.*, 130 Ga. 726, 730, 61 S. E. 704, 14 Ann. Cas. 299. In this case the insurance company having absolutely refused to pay the death loss, it was not incumbent upon the plaintiff to furnish proofs of such loss.

- (a) The evidence was sufficient to show a demand by the plaintiff upon the insurance company for the payment of the death loss, and a refusal to pay by the company.

(For other cases, see Insurance, Cent. Dig. §§ 1391, 1392; Dec. Dig. § 559[1].)

3. INSURANCE—CONSTRUCTION OF POLICY—ENTIRE OR SEVERAL POLICY—TERM INSURANCE.

The insurance policy contained the following clause: "The funeral benefit provided under this policy is weekly term insurance renewable at the option of the company." The policy also provided that, for and in consideration of the sum of twenty-five cents as a weekly premium, the company agreed to pay to the insured \$5 as weekly benefits for sickness or accident, and to his beneficiary \$92.50 upon his death. This policy was therefore entire and indivisible, and not several. *Southern Fire Insurance Co. vs. Knight*, 111 Ga. 622, 36 S. E. 821, 52 L. R. A. 70, 78 Am. St. Rep. 216. The promise of the insurance company in this case to pay to the insured funeral benefits and for sickness and accident indemnity was one entire undertaking, not two separate contracts; for the promise was supported by a single and entire consideration. The provision that "the funeral benefit provided under this policy is weekly term insurance renewable at the option of the company" refers solely to the funeral benefits, or death indemnity, and not to the sickness or accident features of the policy. The company must continue this latter element of its insurance as long as the premium is tendered; for no right is retained in the policy to cancel it without the consent of the insured, and, by implication, it is not "weekly term insurance renewable at the option of the company," for only the life insurance element of the policy is so called. See *Alabama Gold Life Insurance Co. vs. Garmany*, 74 Ga. 51; 3 Cooley's Insurance, § 2830, and cases therein cited. It follows that the insurance company had no right to arbitrarily refuse to accept the weekly premiums tendered; as these payments kept in force the sickness and accident features of the policy, as well as the funeral benefit feature. Any other holding would allow insurance companies to fraudulently relieve themselves of all liability whenever the imminence of such liability became apparent to them.

(For other cases, see Insurance, Cent. Dig. §§ 384-390; Dec. Dig. § 179.)

4. INSURANCE—LIABILITY OF INSURER—RELEASE.

It is immaterial that the company procured a sister of the insured to sign a "release" of the policy, as it appears that she was an agent of the insured for the sole purpose of paying a premium due upon the policy, and that she had no authority to sign a release, she being neither the insured nor the beneficiary, and, as the \$20, expressed as a consideration for the release, was in fact the amount which had already been paid as sick benefits under the policy, there was no real consideration for the release.

(For other cases, see Insurance, Cent. Dig. § 1499; Dec. Dig. § 603.)

Error from Superior Court, Fulton County; W. D. Ellis, Judge.

Action by S. H. Jackson against the National Life Insurance Company, etc. Judgment for plaintiff, and defendant brings error. Affirmed.

Lawton Nalley and Thos. E. Scott, both of Atlanta, for Plaintiff in Error.
Foster & Stockbridge, of Atlanta, for Defendant in Error.

LIFE INS. CO. OF VIRGINIA *vs.* PROCTOR. (No. 6904.)*
(Court of Appeals of Georgia.)

2. INSURANCE—PREMIUMS—PAYMENT.

The court erred in overruling the demurrer to the petition as amended, since the petition failed to allege the payment of premiums on the policy of insurance, which payment was a condition precedent to a recovery on the contract. The remaining proceedings were therefore nugatory.

(For other cases, see Insurance, Cent. Dig. § 1584; Dec. Dig. § 629[2].)

Error from Municipal Court of Macon; Hugh Chambers, Judge.
Action by Mattie Proctor against the Life Insurance Company of Virginia. There was a judgment for plaintiff, and defendant brings error. Reversed.

Wm. E. Martin, Jr., of Macon, for Plaintiff in Error.
J. A. Monsees and J. C. Estes, both of Macon, for Defendant in Error.

* Decision rendered, Sept. 16, 1916. 89 S. E. Rep. 1088. Syllabus by the Court.

FAVORS *vs.* BANKERS' HEALTH & LIFE INS. CO.
(No. 7192.)*

(Court of Appeals of Georgia.)

INSURANCE—LIFE INSURANCE—PREMIUMS—RECOVERY.

This was an action to recover the aggregate amount of certain weekly insurance premiums paid by the insured anterior to the forfeiture of two insurance policies, on account of her failure to pay premiums in accordance with the terms of the contract. This contract stipulated that "if agent fails to call for dues, all policyholders are required to remit their premiums to the nearest office of the company, or forfeit what they have paid the company." The fact that the insured had paid premiums before or at the time they fell due, to agents or collectors of the company, would not relieve her from the obligation to remit such premiums directly to the nearest office of the company, where no agent of the company called for or demanded the payment of them when due. Under the allegations in the petition for certiorari,

* Decision rendered, Sept. 16, 1916. 89 S. E. Rep. 1048. Syllabus by the Court.

adopted as true by the judge who tried the case, no course of dealing between the parties appears which in legal effect amounted to a waiver by the insurer of the aforementioned stipulations, or authorized the insured to disregard them. The judge of the superior court did not err in overruling the certiorari.

(For other cases, see Insurance, Cent. Dig. § 459; Dec. Dig. § 198[5].)

Error from Superior Court, Fulton County; J. T. Pendleton, Judge. Action by Adeline Favors against the Bankers' Health & Life Insurance Company. Certiorari was denied by the superior court, and plaintiff brings error. Affirmed.

W. E. Suttles, of Atlanta, for Plaintiff in Error.
Nalley & Scott, of Atlanta, for Defendant in Error.

SUPREME CIRCLE OF BENEVOLENCE *vs.* BEALL. (No. 7141.)*

(Court of Appeals of Georgia.)

INSURANCE—FRATERNAL INSURANCE—PROCESS—SERVICE —LOCAL LODGE.

Under the facts of this case, upon the motion to set aside the judgment against the defendant, the court was authorized to find that the local lodge in Sumter County was an "office and place of business" of the defendant for the transaction of business in that county, and that the local lodge was also the agent of the defendant, the superior or home lodge in Dougherty County, and that service of the plaintiff's suit upon the "chief executive officer" of the subordinate lodge in Sumter County was service upon the defendant.

(For other cases, see Insurance, Cent. Dig. § 1995; Dec. Dig. § 814.)

Error from City Court of Americus; W. M. Harper, Judge.

Action by F. L. Beall against the Supreme Circle of Benevolence. There was a judgment for plaintiff, and defendant brings error. Affirmed.

Wallis & Fort, of Americus, and Pope & Bennet, of Albany, for Plaintiff in Error.

J. E. Sheppard and J. A. Hixon, both of Americus, for Defendant in Error.

* Decision rendered, July 12, 1916. Rehearing denied, July 31, 1916. 89
S. E. Rep. 630. Syllabus by the Court.

PORTER vs. STATE MUT. LIFE INS. CO. (No. 552.)*
 (Supreme Court of Georgia.)

INSURANCE—COMPANIES—ACTIONS—VENUE.

The provisions of section 2563 of the Civil Code of 1910 that, where any person may have any claim or demand against any insurance company having agencies or more than one place of doing business, it shall be lawful for such person to institute suit against such insurance company within the county where the principal office of such company is located, or in any county where it may have an agency or place of doing business, etc., do not authorize the filing of a petition seeking purely equitable relief against an insurance company having its principal office in this state, as the sole defendant, in a county other than where such principal office is located.

(For other cases, see *Insurance*, Cent Dig. §§ 1536-1539; Dec. Dig. § 618.)

Fish, C. J., and Atkinson, J., dissenting.

Error from Superior Court, Miller County; W. C. Worrill, Judge.
 Action by Lula Curry Porter against the State Mutual Life Insurance Company. Judgment for defendant, and plaintiff brings error. Affirmed.

Roscoe Yuke, of Thomasville, and Pottle & Hofmayer, of Albany, for Plaintiff in Error.

Maddox & Doyal, of Rome, and King & Spalding, of Atlanta, for Defendant in Error.

* Decision rendered, July 14, 1916. 89 S. E. Rep. 609. Syllabus by the Court.

SMITH vs. GRAND LODGE KNIGHTS OF PYTHIAS.
 (No. 578.)*

(Supreme Court of Georgia.)

**1. INSURANCE—FRATERNAL BENEFIT INSURANCE—ACTIONS
 —PLEADING.**

A mutual benefit society had certain by-laws, some of which were as follows: "That a bureau of endowment is hereby created, whereby, upon satisfactory proof of the death of a sir knight in good standing who has complied with all the requirements of the order and the laws as are herein set forth, a sum of money named in his certificate shall be paid to his widow, orphans, or dependent relatives in accordance with the provisions hereinafter made, and such other alterations or amendments as shall be adopted by the Grand Lodge from time to time. Every person upon becoming a member of the order, who shall have been charged in the knight rank, shall immediately make application through the lodge for a certificate which will entitle him to

* Decision rendered, Aug. 16, 1916. 89 S. E. Rep. 688. Syllabus by the Court.

the benefits of section 1 in this article. Every knight shall pay to the endowment bureau, through his lodge, the amount prescribed by the Grand Lodge monthly in advance, and it shall be the duty of the master of finances to collect the same in preference to lodge dues, and pay it over to the treasurer of the endowment bureau on or before the 20th day of each month. Every lodge shall forward to the Grand Keeper of Records and Seal all applications for certificates within ten days after the applicant's initiation into the knight rank, with the examining physician's certificate and sixty cents to pay for same. Each applicant shall have entered upon his application the name or names of the person or persons to whom he desires his benefits paid." In an action against the society, brought by a person alleged to be the sister of a deceased member, the petition alleged that the decedent had not obtained a certificate; that after he had been a member for some time his father-in-law fraudulently procured a certificate to be issued in his favor as a beneficiary; that, upon the discovery of this fact, the member wrote to the proper official of the society of which he was a member, repudiating the certificate thus issued, and requesting that the person addressed should obtain the "policy" from the father-in-law of the member and issue a certificate in favor of his sister; that a committee was appointed by the local lodge, of which he was a member, to investigate the matter; that the father-in-law of the member promised to deliver up the certificate, but later stated that he had lost it; that, after the death of the member, proof of death was made, and payment was made to the father-in-law as the holder of the certificate. *Held*, that it did not appear that any certificate had been issued which named the plaintiff as the beneficiary, or that she was one of the class of persons named in the by-laws who might be made beneficiaries of such certificates. She neither showed that she was an actual beneficiary in a certificate, nor that she was one who in equity was entitled to be treated as a beneficiary, or to enforce the rights of a beneficiary.

- (a) If the petition be treated as one seeking to enforce a change of beneficiaries, it failed to show that there had been a compliance with another section of the by-laws, requiring for that purpose the production of an affidavit, and the payment of a small sum of money.

(For other cases, see *Insurance, Cent. Dig.* § 1996; *Dec. Dig.* § 815[1].)

Error from Superior Court, Richmond County; H. C. Hammond, Judge.

Action by Agnes Smith against the Grand Lodge Knights of Pythias. Judgment for defendant, and plaintiff brings error. Affirmed.

Jas. S. Bussey, Jr., and Geo. T Jackson, both of Augusta, for Plaintiff in Error.

Oswell R. Eve, of Augusta, for Defendant in Error.

SOUTHERN STATES LIFE INS. CO. *vs.* WARNOCK.

(No. 638.)*

(Supreme Court of Georgia.)

I. INSURANCE—LIFE INSURANCE—ACTIONS—NOTICE.

Suit was brought on a policy of life insurance, by one clause of which the insurer bound itself to pay to the insured a certain sum, "if, after one full annual premium thereon shall have been paid in cash, and the policy is then in full force by the payment of premiums as herein provided, the insured shall furnish to the company due proof that he has become physically disabled and wholly, continuously, and permanently incapacitated from carrying on any gainful occupation," etc. After the alleged disability due proof was submitted to the effect that the insured was physically disabled and wholly, continuously, and permanently incapacitated from carrying on any gainful occupation, "by reason of kidney trouble and cataracts on both eyes," etc. The insurer declined to pay the amount stipulated in the policy, and suit was brought by the insured, alleging, among other things, that the disability was continuous and permanent, that he was permanently incapacitated from carrying on any gainful occupation, that he had suffered the permanent loss of sight of both eyes and a general and complete loss of health, "caused from complications of heart trouble, kidney trouble, piles, and other ailments, the exact cause and character of which are unknown to petitioner." A demurrer to the petition was overruled, and the defendant excepted. On the trial of the case the jury found a verdict for the plaintiff for the amount sued for, with damages on account of the defendant's refusal to pay the claim within sixty days after the notice of disability, and attorney's fees for the prosecution of the case. A motion for a new trial was overruled, and the defendant excepted. All of the grounds of the motion (except as to the sufficiency of evidence to support the finding of the jury, and as to the right of the plaintiff to recover damages and attorney's fees), whether objections to evidence, charges given by the court, or refusals to charge revolve around one question, namely, whether the fact that the proof of disability which was submitted to the defendant insurer prior to the institution of the suit did not include "heart trouble or the piles," as set forth in the petition, would prevent the plaintiff from recovering for disability not resulting from causes not stated in the notice. *Held*, the clause of the policy set forth above, and by virtue of which the plaintiff sues, does not contemplate giving notice to the company of the causes of disability, but of the disability itself, which was done in this case. Although the plaintiff may have attributed his disability to particular causes at the time of the notice, yet, when he brought his suit and described other causes, he could properly make such allegation and offer proof to sustain them.

(For other cases, see Insurance, Cent. Dig. § 1358; Dec. Dig. § 552.)

Error from Superior Court, Emanuel County; J. B. Park, Judge.
Action by J. A. Warnock, administrator, against the Southern States Life Insurance Company. There was a judgment for plaintiff, and defendant brings error. Affirmed on condition.

* Decision rendered, Sept. 12, 1916. 89 S. E. Rep. 843. Syllabus by the Court.

Williams & Bradley, of Swainsboro, and Atkinson & Born, and Jackson & Orme, all of Atlanta, for Plaintiff in Error.

T. N. Brown and Saffold & Jordan, all of Swainsboro, for Defendant in Error.

RETERFORD vs. KNIGHTS AND LADIES OF SECURITY. (No. 30580.)*

(Supreme Court of Iowa.)

1. INSURANCE—FRATERNAL BENEFIT INSURANCE—ACTIONS—QUESTION FOR JURY.

In an action on a benefit certificate, evidence held to present a question for the jury as to the date of delivery of the certificate as affecting the question of application of payments by the insured.

(For other cases, see Insurance, Cent. Dig. § 2009; Dec. Dig. § 825[2].)

Appeal from District Court, Lucas County; D. M. Anderson, Judge. Action upon a life insurance certificate issued by the defendant to Eva M. Retherford, now deceased, who was the wife of plaintiff. Plaintiff was the beneficiary named in the certificate. There was a trial to a jury. At the conclusion of the evidence the court sustained the defendant's motion for a directed verdict in its favor. Judgment was rendered in favor of defendant, and plaintiff appeals. Reversed and remanded for new trial.

W. W. Bulman, of Charlton, for Appellant.
Stuart & Stuart, of Charlton, for Appellee.

* Decision rendered, Sept. 29, 1916. 159 N. W. Rep. 185.



FRICK vs. HARTFORD LIFE INS. Co. (No. 30368.)*

(Supreme Court of Iowa.)

2. INSURANCE—FOREIGN CORPORATION—JURISDICTION—STATUTE.

Under Code 1897, §§ 1794, 1808, providing that on complying with the law the state auditor shall issue to a foreign insurance company a certificate of authority to do business in the state, and that on receiving such certificate it shall file with the state auditor an agreement that process may be served on him, the district court had jurisdiction of a foreign insurance corporation, defending an action in which notice and return of service had been according to statute, especially where the defendant appeared and filed its demurrer.

(For other cases, see Insurance, Cent. Dig. § 1573; Dec. Dig. § 627[2].)

* Decision rendered, Sept. 29, 1916. 159 N. W. Rep. 247.

3. INSURANCE—MUTUAL INSURANCE COMPANY—RIGHTS OF MEMBERS.

In a mutual company a member's rights are determined, not only by the contract, but by the charter, constitution, and by-laws.

(For other cases, see Insurance, Cent. Dig. § 66; Dec. Dig. § 54.)

4. INSURANCE—FOREIGN CORPORATIONS—ACTIONS—JURISDICTION OF SUBJECT-MATTER.

Under Code 1897, § 1639, providing that all foreign corporations doing business in the state shall be subject to all the liabilities imposed upon domestic corporations, the district court had jurisdiction of a suit to enjoin the defendant, a foreign insurance company doing business in the state, from assessing plaintiff at a rate in excess of that provided in its contracts, for an accounting of the amount illegally collected from plaintiff in excess of such rates, and for judgment against defendant for the amount found to be due, since, where defendant did not appear to be a mutual company, it was alone liable and the result could not affect any other policyholder, and since the action did not involve the production of the defendant's books and papers, or any complicated account involving the rights of every other policyholder, or an interference with the internal management of the defendant's business.

(For other cases, see Insurance, Cent. Dig. § 1535; Dec. Dig. § 617.)

5. INSURANCE—FOREIGN CORPORATIONS—JURISDICTION—ENFORCEMENT OF JUDGMENT.

In such action, the plaintiff's right would be fixed, and he may pay or tender the assessments in the amounts fixed by the court, and, when the policies mature at his death, the question as to enforcing payment might be then litigated, and the court would not assume in advance that the defendant would not comply with any decree that might be entered, or the possibility that the decree could not be enforced.

(For other cases, see Insurance, Cent. Dig. § 1535; Dec. Dig. § 617.)

Appeal from District Court, Linn County; F. O. Ellison, Judge.

Jones, Hocker, Hawes & Angert, of St. Louis, Mo., Dawley, Jordan & Dawley, of Cedar Rapids, and F. W. Lehmann, Jr., of Des Moines, for Appellant.

Deacon, Good, Sargent & Spangler, of Cedar Rapids, for Appellee.

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HORNER vs. HEINECKE ET AL.*

(Court of Errors and Appeals of New Jersey.)

1. INSURANCE—EXCESS DUES—OWNERSHIP.

A beneficial society acquired no title to excess dues paid by the members thereof pursuant to an order of the Court of Chancery providing in effect that they be deemed involuntary payments to be returned if

* Decision rendered, June 19, 1916. 98 Atl. Rep. 393. Syllabus by the Court.

determined by the court to have been unlawfully exacted; it appearing that the court had so determined. Such excess fund will be deemed to be a trust fund held by the society for the benefit of the members who paid it.

(For other cases, see Insurance, Cent. Dig. § 1888; Dec. Dig. § 743.)

2. INSURANCE—EXCESS DUES—TRUST FUND—ASSENT OF BENEFICIARIES.

The mere fact that not all of the members of a beneficial society who were entitled to a fund held by it for their benefit formally assented to the segregation of the fund and placing it in the hands of other trustees for their benefit is no reason for setting aside the transfer, since, in the absence of anything appearing to the contrary, it will be assumed that they all assented to an action so clearly beneficial to them.

(For other cases, see Insurance, Cent. Dig. § 1888; Dec. Dig. § 743.)

3. INSURANCE—EXCESS DUES—DEATH BENEFIT FUND—TRANSFER OF MORTGAGE.

Where a beneficial society held certain unlawfully exacted excess dues in trust awaiting the result of litigation, and, instead of keeping it in the form of cash, used it to pay death benefits, so that the death benefit fund became indebted to the excess fund, it was legitimate for the society to use the mortgages in which the death benefit fund was invested to discharge the known indebtedness of that fund to the excess fund.

(For other cases, see Insurance, Cent. Dig. § 1888; Dec. Dig. § 743.)

4. INSURANCE—EXCESS DUES—REPAYMENT.

When a beneficial society used cash belonging to an excess dues trust fund to pay death benefits, keeping separate accounts so that the exact amount of the indebtedness of the death benefit fund to each member entitled to a share of the excess fund was capable of being ascertained, then, upon the same being so ascertained, it was proper for the society to pay the money due to the excess fund from the death benefit fund out of the assets of the latter.

(For other cases, see Insurance, Cent. Dig. § 1888; Dec. Dig. § 743.)

5. INSURANCE—EXCESS DUES—LIABILITY FOR INTEREST.

A beneficial society that uses to its own profit funds held in trust awaiting the result of litigation is liable for interest on the amount at a rate conformable to the rate it would have had to pay if it had borrowed elsewhere the money for such use.

(For other cases, see Insurance, Cent. Dig. § 1888; Dec. Dig. § 743.)

Appeal from Court of Chancery.

Bill in equity by John G. Horner, receiver, etc., against George W. Heinecke and others. From a decree dismissing the bill, the complainant appeals Affirmed.

Oscar B. Redrow, of Camden, for Appellant.
John F. Harned, of Camden, for Appellees.

HASKEW *vs.* KNIGHTS OF MODERN MACCABEES.

(No. 6957.)*

(Supreme Court of Oklahoma.)

1. INSURANCE—FRATERNAL BENEFIT INSURANCE—PROOFS OF LOSS.

In an action on a benefit certificate of a fraternal insurance association, the plaintiff must prove a reasonable compliance with the requirements of the association as to the furnishing of proofs of death.

(For other cases, see Insurance, Cent. Dig. §§ 1999, 2000; Dec. Dig. § 817[1].)

2. INSURANCE—FRATERNAL BENEFIT INSURANCE—PROOFS OF LOSS.

A member of a fraternal insurance association, in his application for membership, agreed that no claim by his beneficiary should be valid until proofs were made and filed, establishing such claim in accordance with the laws, rules, and regulations of the association in force at the time such claim was made. Upon the death of the insured, and after proofs were received, the association requested that the proofs be made in a manner not provided for in the laws, rules, and regulations. *Held*, that the officers of the association were without power to impose further duties upon the beneficiary as to the manner of making the proofs of death; that the beneficiary could not be required to comply with such unwarranted requests; and that from the record it appears that the proofs of death reasonably complied with the laws, rules and regulations of the association.

(For other cases, see Insurance, Cent. Dig. §§ 1963, 1964; Dec. Dig. § 789[1].)

3. INSURANCE—FRATERNAL BENEFIT INSURANCE—PROOFS OF DEATH—WAIVER OF OBJECTIONS.

Where proofs of death are received and retained without condition or objection, except to demand compliance with certain requests of the association, which requests it had no authority to make, the association will be held to have waived any objections thereto, which it might otherwise have urged.

(For other cases, see Insurance, Cent. Dig. § 1965; Dec. Dig. § 789[2].)

4. INSURANCE—FRATERNAL BENEFIT INSURANCE—ACTIONS—CONDITIONS PRECEDENT.

The failure of a fraternal insurance association to comply with the provision of its by-laws, in regard to the disapproval of death claims, excuses the beneficiary from complying with the further and related provision, that all claims must be submitted to the proper tribunals within the order before commencing a suit in law or equity, and permits such beneficiary to maintain an action on the benefit certificate in the courts of this state, without first having sought relief in the tribunals of the association.

(For other cases, see Insurance, Cent. Dig. § 1987; Dec. Dig. § 805[1].)

Error from District Court, Bryan County; Jesse M. Hatchett, Judge.

* Decision rendered, July 25, 1916. 159 Pac. Rep. 493. Syllabus by the Court.

Action by Mollie Haskew, nee Curington, against the Knights of Modern Maccabees. Judgment for defendant, and plaintiff brings error. Reversed and remanded, with directions.

J. M. Crook, of Oklahoma City, and W. B. Stone, of Durant, for Plaintiff in Error.

Porter Newman, of Durant, Frank E. Jones and S. H. Kyle, of Bisbee, Ariz., for Defendant in Error.



**SOVEREIGN CAMP OF WOODMEN OF THE WORLD *vs.*
HUTCHINS. (No. 7514.)***
(Supreme Court of Oklahoma.)

2. INSURANCE—FRATERNAL INSURANCE—BURDEN OF PROOF.

Where, in an action on a benefit certificate, liability is denied on the ground that a false statement was made by the assured in the application for the certificate, which by its terms voided the same, and it was denied that the assured executed the application or made the false statement, *held*, that it was not error for the court to instruct the jury that the burden was on the defendant to prove the execution of the application and the alleged false statement therein.

(For other cases, see Insurance, Cent. Dig. § 2001; Dec. Dig. § 817[2].)

Commissioners' Opinion, Division No. 2. Error from District Court, Carter County; A. Eddleman, Judge.

Action by Laura E. Hutchins against Sovereign Camp of the Woodmen of the World. There was judgment for plaintiff, defendant appeals. Affirmed.

See, also, 39 Okla. 267, 134 Pac. 1116.

N. B. Maxey and Kelly Brown, both of Muskogee, for Plaintiff in Error.

Potter & Walker, of Ardmore, for Defendant in Error.

* Decision rendered, June 27, 1916. Rehearing denied, Sept. 12, 1916. 159 Pac. Rep. 920. Syllabus by the Court.



SCHRINER ET AL. *vs.* SACHS ET AL.*
(Supreme Court of Pennsylvania.)

INSURANCE—FRATERNAL INSURANCE—ASSETS—INCORPORATION.

A fraternal insurance order, originally incorporated in New Jersey, surrendered its charter and obtained a charter in Pennsylvania. After

* Decision rendered, May 15, 1916. 98 Atl. Rep. 724.

the surrender of the New Jersey charter, and before completion of the Pennsylvania incorporation, a majority of the members of a subordinate body withdrew from the parent body, taking with them the assets and united with another order. A minority of the members of such subordinate body sued to compel surrender of the assets. *Held*, that the surrender of the New Jersey charter did not work a dissolution of the order, so as to authorize a diversion of its properties and assets by the subordinate bodies, and the assets might be recovered.

(For other cases, see Insurance, Cent. Dig. § 1838; Dec. Dig. § 697.)

Appeal from Court of Common Pleas, Philadelphia County.

Bill by Howard M. Schriner and others, on behalf of themselves and the other officers, trustees, and members of the Quaker City Circle No. 97, Brotherhood of America of the State of Pennsylvania, against John Sachs, Sr., and others, officers, trustees, and members of the said circle. From a decree for complainants, defendants appeal. Affirmed.

Argued before Brown, C. J., and Mestrezat, Stewart, Frazer, and Walling, JJ.

Chester N. Farr, Jr., of Philadelphia, for Appellants.
Frank M. Cody, of Philadelphia, for Appellees.

WILLIAMS *vs.* PHILADELPHIA LIFE INS. CO. *et al.*
(No. 9490.)*

(Supreme Court of South Carolina.)

2. INSURANCE—DELIVERY OF POLICY—EFFECT OF MAILING.
When the insurer mails its policy to the applicant delivery is complete, and liability attaches as soon as the policy is placed in the postoffice, in the absence of notice of refusal on good grounds by the applicant to accept it as issued.

(For other cases, see Insurance, Cent. Dig. §§ 220, 221, 226, 227; Dec. Dig. § 136[2].)

3. INSURANCE—DELIVERY OF POLICY—EFFECT OF MAILING TO AGENT.

When the insurer mails its policy to its agent for delivery to the applicant without contemplation of further action, delivery is complete and liability attaches, though the agent wrongfully fails to deliver it.

(For other cases, see Insurance, Cent. Dig. §§ 220, 221, 226, 227; Dec. Dig. § 136[2].)

5. INSURANCE—ACTIONS—PLEADING—PRESUMPTION.

From allegations in complaint that arrangements satisfactory to the insurer had been made for payment of the premium, and that the policy

* Decision rendered, Aug. 10, 1916. 89 S. E. Rep. 675.

was issued and forwarded to the agent for delivery to the applicant, it will be presumed that the delivery was intended to be unconditional, and hence failure of the agent to deliver was wrongful.
(For other cases, see Insurance, Cent. Dig. § 1584; Dec. Dig. § 629[2].)

Appeal from Common Pleas Circuit Court of Lancaster County; I. W. Bowman, Judge.

Action by H. T. Williams, administrator of the estate of Margaret E. Williams, against the Philadelphia Life Insurance Company and others. From an order sustaining demurrer to the complaint, plaintiff appeals. Reversed.

Williams & Williams and Jones & Jones, all of Lancaster, for Appellant.

Wilson & Wilson, of Rock Hill, and Stack & Parker, of Monroe, N. C., for Respondents.

SILLIMAN *vs.* INTERNATIONAL LIFE INS. CO.*

(Supreme Court of Tennessee.)

1. INSURANCE—LIFE POLICIES—STATUTES—CONSTRUCTION —“NOT IN GOOD FAITH.”

In Acts 1901, c. 141, § 1, as to penalties for refusing to pay a policy, the words “not in good faith” are antithetical to “in good faith,” and imply a lack of good or moral intent as the motive for refusal to pay the loss.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

(For other definitions, see Words and Phrases, First and Second Series, Good Faith.)

2. INSURANCE—LIFE POLICIES—REFUSAL TO PAY LOSS— RIGHT TO STATUTORY PENALTY.

Under such statute, the right to recover the penalty is conditional and does not exist where the right to recover the face of the policy has been forfeited by failure to pay premiums, or where the refusal is in good faith.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

3. INSURANCE—LIFE POLICIES—REFUSAL TO PAY LOSS— RIGHT TO STATUTORY PENALTY—EVIDENCE.

Evidence held insufficient to show that insurer’s refusal to pay loss on life policy was not in good faith.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

5. INSURANCE—LIFE POLICIES—REFUSAL TO PAY LOSS— RIGHT TO STATUTORY PENALTY—EVIDENCE.

In view of differences of opinion as to statutory construction and determinative facts, an insurer is not necessarily liable for refusal to pay

* Decision rendered, Aug. 9, 1916. 188 S. W. Rep. 273.

a loss as made in bad faith, on the ground that its attorneys should have known the law fixing liability on the policy.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

Appeal from Chancery Court, Giles County; Walter S. Bearden, Chancellor.

Suit by Mattie I. Silliman against the International Life Insurance Company. From a judgment for plaintiff, defendant appeals. Bills dismissed.

See, also, 131 Tenn. 303, 174 S. W. 1131, L. R. A. 1915F, 707.

E. E. Eslick, of Pulaski, for Appellant.
Childers & Woodward, of Pulaski, for Appellee.

SOUTHERN UNION LIFE INS. CO. *vs.* WHITE.

(No. 5625.)*

(Court of Civil Appeals of Texas. Austin.)

1. INSURANCE—LIFE POLICY—INCONTESTABILITY—FRAUD.

Under Rev. St. 1911, art. 4741, requiring every policy to contain a clause providing that the policy shall be incontestable after two years from its date, except for nonpayment of premiums, a life policy, providing "this policy shall be incontestable after it has been in force one year, providing the premiums have been duly paid," was not contestable four years after it was issued, on the ground that it was obtained by fraudulent representations of the insured as to his health and use of alcoholic drinks.

(For other cases, see Insurance, Cent. Dig. § 1086; Dec. Dig. § 400.)

2. INSURANCE—LIFE INSURANCE—FRAUD AS A DEFENSE—BENEFICIARY PARTICIPATING.

Where it was not permissible, because of the incontestable clause in a policy of life insurance, to show that the insured committed fraud in obtaining the policy, it was not permissible to show that the beneficiary participated in such fraud.

(For other cases, see Insurance, Cent. Dig. §§ 1677, 1680, 1681, 1685; Dec. Dig. § 655(2).)

3. INSURANCE—LIFE INSURANCE—NON-PAYMENT OF LOSS—PENALTY—DEMAND.

In an action on a life policy, where demand for the payment of loss was not made thirty days before the filing of the original petition, but an amended petition, alleging such demand was filed more than thirty days after demand, plaintiff was entitled to recover the 12 per cent statutory penalty and attorney's fees.

(For other cases, see Insurance, Cent. Dig. §§ 1805, 1806; Dec. Dig. § 675.)

* Decision rendered, May 17, 1916. Rehearing denied, June 28, 1916. 188 S. W. Rep. 266.

Appeal from District Court, Brown County; John W. Goodwin, Judge.
Action by Mrs. Mayme Louise White against the Southern Union Life Insurance Company. Judgment for plaintiff and defendant appeals. Affirmed.

G. N. Harrison, of Brownwood, and Cross & Street, of Waco, for Appellant.

McCartney & McGee, of Brownwood, for Appellee.



NORTHWESTERN MUT. LIFE INS. CO. vs. WHITESELLER. (No. 1634.)*

(Court of Civil Appeals of Texas. Texarkana.)

INSURANCE—INSURABLE INTEREST—EFFECT OF DIVORCE.

A wife, named as beneficiary in a life policy to her husband, on being divorced, ceased to have any interest as beneficiary in the policy. (For other cases, see Insurance, Cent. Dig. §§ 168-171; Dec. Dig. § 123.)

Error from District Court, Navarro County; H. Clay Nash, Judge.

Action by J. E. Whiteselle, executor, against the Northwestern Mutual Life Insurance Company. Judgment for plaintiff, and defendant brings error. Reversed and rendered.

Locke & Locke, of Dallas, for Plaintiff in Error.

Richard Mays, of Corsicana, for Defendant in Error.

* Decision rendered, June 8, 1916. Rehearing denied, June 29, 1916. 188 S. W. Rep. 22.



FITZGERALD vs. METROPOLITAN LIFE INS. CO.*

(Supreme Court of Vermont. Rutland.)

1. INSURANCE—DUTIES OF APPLICANT—KNOWLEDGE OF ILL HEALTH.

The duty of the applicant for life insurance to disclose a material change for the worse in his health, after the making of the application and medical examination and before the issuance of the policy, implies knowledge on the applicant's part of such change.

(For other cases, see Insurance, Cent. Dig. § 552; Dec. Dig. § 259.)

2. INSURANCE — REPRESENTATIONS AND WARRANTIES — EFFECT.

If the truth of the matter stated in application for insurance is warranted,

* Decision rendered, Aug. 14, 1916. 98 Atl. Rep. 498.

its falsity will avoid the policy, though not material; but, if it is a mere representation, its falsity will not avoid the policy, unless the matter is material.

(For other cases, see Insurance, Cent. Dig. §§ 548, 568, 569; Dec. Dig. §§ 255, 268.)

3. INSURANCE—REPRESENTATIONS—MATERIALITY.

Insurance procured by means of representations which are undoubtedly fraudulent, and are in fact relied upon, is voidable, though the statements relate to immaterial matters.

(For other cases, see Insurance, Cent. Dig. § 540; Dec. Dig. § 256[2].)

4. INSURANCE — MISREPRESENTATION — FRAUDULENT INTENT.

There is ample authority for saying that representations regarding material matter, which are false in fact, will avoid the policy, though not fraudulently made.

(For other cases, see Insurance, Cent. Dig. § 540; Dec. Dig. § 256[2].)

6. INSURANCE — ACTIONS — QUESTIONS FOR JURY — MATERIALITY OF REPRESENTATIONS.

Materiality of representations as to residence, occupation, and financial condition is ordinarily for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1737-1740, 1758-1760; Dec. Dig. § 668[6].)

7. INSURANCE — MISREPRESENTATIONS — MATTER STATED AS OF APPLICANT'S KNOWLEDGE.

Where the applicant for life insurance assumes to have knowledge of a matter which the insurer might reasonably suppose to be within her knowledge, and the statements made are in fact false, the law, in the absence of exception, infers an intent to deceive.

(For other cases, see Insurance, Cent. Dig. § 540; Dec. Dig. § 256[2].)

8. INSURANCE — APPLICATIONS — REPRESENTATIONS—MATERIALITY.

False answers, which close inquiry as to material matters, may themselves be material.

(For other cases, see Insurance, Cent. Dig. § 548; Dec. Dig. § 255.)

14. INSURANCE—DELIVERY OF POLICY—ACTS OF SOLICITING AGENT.

There being no evidence that the policy was given the agent for unconditional delivery, it cannot be presumed that, in further questioning the beneficiary in the absence of the insured, the agent acted at variance with his instructions.

(For other cases, see Insurance, Cent. Dig. §§ 1555, 1645-1649; Dec. Dig. § 646[1].)

On Rehearing.

16. INSURANCE—ACTIONS—INSTRUCTIONS.

Instruction that if beneficiary induced insurer's agent to deliver policy by false representations as to health of insured, the policy never took effect, *held* correct, and applicable under the evidence.

(For other cases, see Insurance, Cent. Dig. §§ 557, 1774-1776; Dec. Dig. §§ 262, 669[7].)

17. INSURANCE—LIFE INSURANCE—MISREPRESENTATIONS—EFFECT.

Evidence *held* to bring beneficiary within the rule that misrepresentations made as of a party's own knowledge, if false in fact, are inferred to have been wilfully false, if unexplained.

(For other cases, see Insurance, Cent. Dig. §§ 1711-1716; Dec. Dig. § 665[3].)

20. INSURANCE—DELIVERY OF POLICY—EFFECT OF FRAUD.

Mutual binding intention that contract of insurance shall be complete when terms are agreed on, and only execution and delivery remain to be done, does not exist, where one party's action is induced by fraud.

(For other cases, see Insurance, Cent. Dig. § 557; Dec. Dig. § 262.)

21. INSURANCE—DELIVERY OF POLICY—EFFECT OF FRAUD.

When there is a claim of fraud in the application, as well as in the procurement of the policy, it cannot be said that the transmission of the policy to the agent is the same as a delivery to the insured, without considering whether there was that mutuality of agreement and intention which excuses the actual delivery.

(For other cases, see Insurance, Cent. Dig. §§ 220, 221, 226, 227; Dec. Dig. § 136[2].)

23. INSURANCE—VALIDITY OF POLICY—EFFECT OF FRAUD.

Date and terms of policy, relation of its provisions to dates stated, acknowledgment of receipt of first premium, and actual issuance of policy do not determine its effective date, if induced by fraudulent representations.

(For other cases, see Insurance, Cent. Dig. § 557; Dec. Dig. § 262.)

24. INSURANCE—VALIDITY OF POLICY—EFFECT OF FRAUD.

Instruction that transmission of policy to agent was delivery to insured *held* erroneous, in view of evidence tending to show fraud in the application and in securing delivery.

(For other cases, see Insurance, Cent. Dig. § 1772; Dec. Dig. § 669[2].)

Exceptions from Bennington County Court; Frank L. Fish, Judge.

Assumpsit by Mary E. Fitzgerald against the Metropolitan Life Insurance Company. Judgment for plaintiff, and defendant brings exceptions. Reversed and remanded. Stay of entry of judgment was granted, and plaintiff moved for a rehearing. Motion overruled, and stay of entry vacated.

Argued before Munson, C. J., and Watson, Hazelton, Powers, and Taylor, JJ.

Holden & Healy and D. A. Guiltinan, all of Bennington, for Plaintiff. W. B. Sheldon, of Bennington, F. C. Archibald, of Manchester Center, and Martin T. Nachtmann, of Albany, N. Y., for Defendant.

FIRE, TORNADO, ETC.**SUPREME JUDICIAL COURT OF MAINE**

BRAGG

vs.

ROYAL INS. CO., LIMITED.*

2. INSURANCE — FIRE POLICIES — ACTIONS — BURDEN OF PROOF.

In an action on a fire policy, where the insurer refused payment on the ground of mutual cancellation, it has the burden of proving the same. (For other cases, see Insurance, Cent. Dig. §§ 1555, 1645-1649; Dec. Dig. 646[1].)

3. INSURANCE—FIRE POLICIES—MUTUAL CANCELLATION.

A fire policy provided for cancellation on ten days' notice in writing to the insured, and not otherwise save by mutual agreement. The insured, being informed by the agent that the insurer proposed to cancel the policy and that it had a right to cancel on a minute's notice, surrendered his policy and received the unearned portion of the premium. *Held* that, in view of the usual ignorance of the terms of an insurance policy, the cancellation cannot be deemed mutual, and the insured's consent was not a waiver of the written notice; therefore the cancellation was not binding.

(For other cases, see Insurance, Cent. Dig. §§ 500-502; Dec. Dig. § 229[2].)

Report from Supreme Judicial Court, Somerset County, at Law. Action by Elmer E. Bragg against the Royal Insurance Company, Limited. On report. Judgment for plaintiff.

Argued before Savage, C. J., and Cornish, King, Bird, Haley, and Philbrook, JJ.

Fred H. Lancaster, of Auburn, and Harry Manser, of Lewiston, for Plaintiff.

A. K. Butler, of Skowhegan, for Defendant.

SAVAGE, C. J.

[1] This action upon an insurance policy comes before this court on report. The issuing of the policy and the loss by fire are admitted. The defendant pleaded the general issue, and specially by way of brief statement that the policy sued upon was canceled and surrendered by mutual agreement before the fire.

The defendant contends in argument, also, that the policy was forfeited and void by reason of nonoccupancy, long before the alleged mutual cancellation, and therefore that it is immaterial whether there was a cancellation or not. We do not think this

* Decision rendered, Sept. 18, 1916. 98 Atl. Rep. 632.

defense is open to the defendant now. Not only did the defendant fail to plead nonoccupancy, but in a letter to the plaintiff's counsel before suit was brought it said:—

"The position of the Royal Insurance Co., Ltd., is that this policy was canceled by mutual agreement with Elmer E. Bragg, and therefore this company does not owe him any money."

It said nothing more. It may not be true in every case that a denial by an insurance company upon one ground will preclude it from setting up other grounds of nonliability, although it is held in some cases that a refusal to pay, based on one specified ground will waive other grounds. 2 May on Insurance, § 504A, citing German Ins. Co. vs. Ward, 90 Ill. 550; Marston vs. Mass. Life Ins. Co., 59 N. H. 92; Ben Franklin Fire Ins. Co. vs. Flynn, 98 Pa., 628. See, also, Smith vs. German Ins. Co., 107 Mich. 270, 65 N. W. 236, 30 L. R. A. 368. The defendant's letter and its pleading might well have led the plaintiff to understand that mutual cancellation was the only defense to be offered, and to prepare and present his case accordingly. And apparently it was so presented below. The case having been reported upon the evidence, without rulings or findings, we think the defendant ought not now to be allowed to take advantage of a point which was not only not disclosed by the pleading, but which the defendant's letter and pleading gave the plaintiff reason to believe would not be set up. It has waived all other defenses than the one disclosed.

[2, 3] To recur then to the question of mutual cancellation of the policy. The burden of showing it is, of course, on the defendant. Rosen vs. Ins. Co., 106 Me. 229, 76 Atl. 688; Bard vs. Ins. Co., 108 Me. 506, 81 Atl. 870. The evidence is conflicting in some respects. But we think the weight of it supports the following statement of facts: The premises had been occupied by the plaintiff's tenant. A few days before the attempted cancellation, the tenant left them, upon the assurance, as he says, of the defendant's agent that the policy would remain in force, if he stayed on the premises from Saturday to Monday each week. Shortly after the agent called the plaintiff to his office and informed him that the company would not continue the policy under such conditions, and had instructed him to cancel it. The plaintiff said he would have the tenant go back, or that he would occupy the premises himself. The agent replied that that would not do any good, that the policy was already canceled, and told the plaintiff to bring in his policy and he would return to him the unearned premium. The plaintiff afterward surrendered his policy and received the premium.

The policy was in the standard form prescribed by statute. R. S. c. 49, § 5. Under the terms of the policy the company could cancel the policy after giving the insured ten days' notice in writing and tendering a ratable proportion of the premium, and not otherwise, except by mutual agreement. In this case no notice in writing was given, and no unearned premium tendered at the

time. Therefore to establish cancellation mutual assent must be shown. In other words, it must be shown that the plaintiff waived his contract right to written notice.

It was held in effect in *Rosen vs. Ins. Co.*, *supra*, and *Bard vs. Ins. Co.*, *supra*, that where an insured was in fact ignorant of the requirement for ten days' written notice, and ignorantly consented to a cancellation of his policy, it was no waiver of his contract right to notice. For a waiver is the voluntary relinquishment of a known right. But the defendant seeks to distinguish this case from the Rosen and Bard Cases on the ground that it does not affirmatively appear that the plaintiff was ignorant of his right. As to this, we say, first, that he who sets up a waiver must prove it. He must prove all the elements that create a waiver. It was incumbent on the defendant to prove that the plaintiff voluntarily relinquished a known right. This it has not done. Again, we think it cannot be said that there is no evidence of the plaintiff's ignorance. It is true that he was not asked directly whether he knew. The agent was asked if he himself knew, and he admitted that he did not at the time. The conduct of the plaintiff points, we think, almost indisputably to the inference of his ignorance of his right. Among other things the plaintiff testified that he asked the agent if he "didn't have any notice or anything," and that the agent replied, "No, we can cancel it at a minute's notice." This statement is not denied by the agent. If the plaintiff had then known that he was entitled to ten days' notice in writing, it is inconceivable that he would have taken the agent's assurance as true, which his subsequent conduct shows that he did. He acted upon that assurance, without further protestation as to the right of the company to cancel without notice. And it is not too much to say, in view of common experience, that it ought not to require much evidence to show that ordinarily the insured are not familiar with all the provisions of their insurance policies.

We think this case falls within the doctrine established by the Rosen and Bard Cases. Like the Rosen Case it is a case, as the court then said, where—"the agent, thinking he had the right, notified the insured of immediate cancellation, and the insured, ignorant of the protecting provision of his policy, made no resistance."

Accordingly we hold that, although the plaintiff did consent to the cancellation of his policy, he consented in ignorance of his contract right, and that his consent did not constitute a waiver of written notice as the policy provided. The policy remained in force until the time of the fire.

Judgment for the plaintiff for \$675, and interest from the date of the writ.

SUPREME COURT OF MICHIGAN.

MARX

vs.

WILLIAMSBURGH CITY FIRE INS. CO. (No. 273.)*

1. INSURANCE — INSURABLE INTEREST — SEVERABLE CONTRACT—PURCHASE OF LAND.

Under section 2, Act No. 313, Pub. Acts 1887, entitled "An act to provide for the regulation of the business of selling and furnishing intoxicating liquors," amended by the Pub. Acts 2d Ex. Sess. 1912, No. 1 (How. Ann. St. § 5056), to provide that no wholesaler should enter into any contract with any person authorized to sell such liquors at retail whereby such retailer should be required to handle the wholesaler's liquor exclusively, and that all such contracts should be void, an executory contract between the plaintiff, an officer of and interested in a brewing company, whereby he contributed \$2,500 and the insured \$1,000 to a purchase of a saloon and fixtures, reciting that the \$2,500 remained unpaid, and containing a provision that no beer except that manufactured by plaintiff's company should be handled by the insured, was severable, and, if void as to the provision for the exclusive sale of beer, was a lawful contract supported by a consideration, so that the insured acquired an insurable interest in the premises, and, as between himself and the insurer, the policy on the saloon, fixtures, etc., was valid.

(For other cases, see Insurance, Cent. Dig. § 150; Dec. Dig. § 115[6].)

2. INSURANCE—USE OF PROPERTY—CONDITIONS—BREACH—WAIVER.

Under a policy of insurance covering saloon property and fixtures, providing that it should be void if illuminating gas was generated in the building, where it appeared that gas was so generated when the policy was issued, as known to defendant's agent, there was a waiver of any condition of the policy as to the generation of gas in the building, and a subsequent change in method, without the knowledge of the insurer, was not a breach of the condition, and hence did not avoid the policy.

(For other cases, see Insurance, Cent. Dig. § 1027; Dec. Dig. 388[3].)

3. INSURANCE—PROOFS OF LOSS—RECOVERY.

Under a policy upon a saloon and fixtures, where it appeared that the atmosphere was charged with gasoline fumes and that the lighting of a match was followed by an explosion, and there was testimony that it was not the fault of the lighting apparatus, the statement in the proof of loss that the cause of the fire was unknown, without detailing the facts, in the absence of any showing that insured was guilty of such fraud or false statements as to avoid the policy, or that the insurer was deceived or deprived of the knowledge supposed to be afforded by the proof of loss, did not avoid the policy.

(For other cases, see Insurance, Cent. Dig. § 1343; Dec. Dig. § 542[4].)

Decision rendered, July 21, 1916. 158 N. W. Rep. 1052.

Error to Circuit Court, Wayne County; George S. Hosmer, Judge. Action by Frank Marx against the Williamsburgh City Fire Insurance Company. Judgment for plaintiff, and defendant brings error. Affirmed.

One Jacob Wahl owned certain premises upon which he conducted a saloon. In the saloon were goods used in the business. Otto D. Neifert had \$1,000 in money and wanted to buy the property, the purchase price of which, including the personal property, was \$3,500. An arrangement was made according to which the property was conveyed by Wahl to plaintiff, who paid for it, and plaintiff and Neifert made an executory contract for the sale of the realty to Neifert. Plaintiff was an officer of and interested in a concern which manufactured and sold beer. In the Marx-Neifert contract there was a clause reading:—

"It is further provided and agreed as a part hereof that no beer except than manufactured by the Marx Brewing Company, or its successors or assigns, shall be sold, handled, or dealt in by said second party, his heirs, or assigns, on said premises, so long as said premises shall be used for saloon purpose; the deed provided for in this contract to contain the same provision."

Neifert contributed \$1,000 and Marx \$2,500 in the purchase from Wahl, and the contract sale price was \$3,500; it being recited therein that \$1,000 was payable at its date and that \$2,500 remained unpaid. By its policy, issued May 8, 1913, expiring May 8, 1914, issued to Neifert, defendant insured the building in which was the saloon, including permanent fixtures for heating and lighting, for \$600, a barn for \$200, certain saloon fixtures for \$200, and the stock of merchandise for \$400, "loss, if any, payable to Frank Marx, mortgagee, as his interest may appear." Application was made to and the policy issued by a local agent of defendant at Flat Rock, where the property is.

When the policy was issued the saloon was lighted by gas generated from gasoline, the system being what is known as a hollow wire gasoline lighting system, in which gasoline was carried to burners in a hollow copper wire and gas generated at the burners. The policy did not permit gasoline lighting, but the agent of defendant who issued the policy knew that for some years the system was employed in lighting the saloon. On October 16, 1913, the system of lighting was changed; gasoline being thereafter forced from the tank to a generator, where it was generated by heat into gas, and gas being then forced through 1½-inch galvanized iron pipes to the burners. Of this change the agent and defendant had no notice or knowledge. On October 18, 1913, the insured property was destroyed by fire, immediately preceded, it seems, by an explosion caused by a lighted match in the neighborhood of the generator. Neifert, in his proofs of loss, stated the origin of the fire to be unknown. He testified that in his opinion it was gas in the building and the lighted match. The insured assigned his policy and cause of action after the fire to plaintiff, in whose favor a jury returned a verdict for the value of the policy, upon which verdict a judgment was entered.

When the land contract was offered in evidence, it was objected that it was void under the provisions of Act No. 1, Public Acts, Second Session, 1912 (2 How. [2d Ed.] 5056). The objection being overruled, defendant excepted. Defendant presented various requests to charge, including requests for a peremptory instruction, and the exceptions to refusal of the court to charge as requested and to the charge as given raise three points urged in this court. The first point is that the land contract is absolutely void, and therefore Neifert was not sole and unconditional owner of the insured property, unless of the personal property only. The second point is that the lighting system in use was by the policy a prohibited system; if knowledge of the system employed when the policy was issued would be a waiver of the condition, there was no knowledge of the

change made after the policy was issued. It is a part of this contention that the use of the prohibited system caused or contributed in causing the fire. The third point is that plaintiff's assignor falsely swore in the proofs of loss that the cause of the fire was unknown. These points having been argued in the brief for appellant, there is added the following:—

"There is also presented three other questions, namely: That the contract was in truth and in fact (if valid here for any purpose) a chattel mortgage (requests 12 and 13, assignment of error 17); that plaintiff may not recover more than the actual money interest which plaintiff's assignor had in the property, namely, \$1,000 (request to charge 14, assignment of error 16); and that the court erred in his remarks to the jury in the charge covered by assignments of error 18 and 19."

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, Brooke, and Person, JJ.

Ward N. Choate and Clifford B. Longley, both of Detroit, for Appellant.

Woodruff & Woodruff, of Wyandotte (Frank W. Atkinson, of Detroit, of counsel), for Appellee.

OSTRANDER, J. (after stating the facts as above).

[1] 1. The statute relied upon is an amendment of section 2 of Act No. 313, Public Acts of 1887, entitled:—

"An act to provide for the taxation and regulation of the business of manufacturing, selling, keeping for sale, furnishing, giving, or delivering spirituous and intoxicating liquors, and malt, brewed, or fermented liquors and vinous liquors in this state, and to repeal all acts or parts of acts inconsistent with the provisions of this act."

It contains the following:—

"Nor shall such wholesaler enter into any contract, agreement or other understanding with any person or firm authorized to sell such liquors at retail, by virtue of which contract, agreement, or other understanding or agreement such retailer shall be required to handle the brand of liquors manufactured or sold by such wholesaler to the exclusion of any or all other brands of liquor; * * * and all such agreements, contracts, or other understanding * * * shall be null and void and of no effect whatsoever."

It is not clear that the statute, or the principle of which it is declaratory, has any application here because plaintiff is not, strictly, a manufacturer or wholesaler of liquor, and it does not appear that the corporation, of which he is an officer, was in any manner interested in, authorized or approved the contract made by plaintiff and Neifert. Assuming that the particular clause of the contract relating to the purchase and sale of beer upon the premises is void, because obnoxious to the statute, whether the entire contract is void depends upon whether it is severable, so that, the illegal agreement being eliminated, there remains a lawful agreement, supported by a lawful consideration. The identical question was presented and decided in Koppitz-Melchers

Brewing Co. vs. Behm, 130 Mich. 649, 90 N. W. 676, and Dierkes vs. Wideman, 143 Mich. 181, 106 N. W. 735, in each of which cases it was held that the contract considered was not severable.

The contract now before us is, I think, plainly a severable one. The owner asked \$3,500 for the property. Plaintiff bought it from the owner, at the solicitation of Neifert, who contributed \$1,000 of the purchase money, and with plaintiff agreed to pay the remainder, with interest, to cause the property to be listed for taxation in his own name, to pay the taxes, keep up the premises, and keep them insured. There is a provision for forfeiting the contract for nonperformance of its covenants, but breach of the promise to sell only Marx Brewing Company beer is not a ground for forfeiture. The testimony does not disclose that the obnoxious stipulation influenced either plaintiff or defendant in making the original arrangement by which plaintiff agreed to buy the property, advance a part of the purchase money, and resell to Neifert.

In the cases I have cited the illegal arrangement was the real arrangement, to which the matters in dispute related and out of which they grew. I conclude that by the land contract Neifert acquired an insurable interest in the premises, and as between himself and the defendant the policy when issued was valid.

[2] 2. The policy of insurance, no agreement to the contrary being thereon indorsed, was by its terms void "if illuminating gas or vapor be generated in the described building or adjacent thereto for use therein." It is conceded that the indicated forbidden thing existed when the policy was issued and that the defendant's agent knew it. It is not claimed that, if no change had been made in the method of generating gas, or vapor, for lighting, the policy would be avoided. But as the defendant's knowledge of the situation was imputed, and its knowledge of the change in method is not and cannot be imputed, the contention is that the condition stands, violated, with the same effect as though no knowledge of conditions had ever come to defendant. The obvious, and in my opinion the conclusive, answer to this reasoning is that the condition relied upon was waived when the policy was issued; that is, it was agreed, in essence, that generating illuminating gas, or vapor, in the described building or adjacent thereto, would not avoid the policy. Defendant is charged with knowledge of the condition existing when the policy was issued, and the condition had not changed when the fire occurred. There was no new, or other, or different, breach of the policy condition after the policy was issued.

[3] 3. No one who testified at the trial claimed to know how the fire originated beyond this: That the atmosphere seemed to be charged with gasoline fumes, and that the lighting of a match was followed by some disturbance described as an explosion. There is testimony to the effect that it was not, probably, the fault of the lighting apparatus. In filing proofs of loss the in-

sured might have described in detail what occurred, since he was present and lighted the match, instead of saying that the cause was unknown. There were several persons in the room at the time, and support for the charge that the insured was guilty of such fraud and false swearing as to avoid the policy, because he gave neither the details as he saw them nor his own opinion of the cause of the fire in his proofs of loss, seems to me to be lacking. It is not pointed out in what respect he thus deceived defendant, or deprived it of the necessary or convenient knowledge that is supposed to be afforded by formal proofs of loss.

These conclusions relieve me from examining other suggested points.

The judgment is affirmed, with costs to appellee.

COURT OF CHANCERY OF NEW JERSEY.

PALMER

vs.

McFADDEN ET AL. (No. 41/52.)*

1. INSURANCE—FIRE INSURANCE—RIGHT OF MORTGAGEE AND MORTGAGOR—LIABILITY—CONTRIBUTION.

Clauses of policy provided that the insurer should not be liable for a greater proportion of loss than its policy bore to the entire amount of insurance, and that if it paid to the mortgagee any loss, and claimed that as the mortgagor no liability existed, it should be subrogated to the rights of the mortgagee, and might pay the mortgage and have an assignment thereof, but that no subrogation should impair the mortgagee's right to recover the full amount of his claim. The policy issued to the mortgagor and contained the standard mortgagee clause. Other insurance was taken, and on loss, the other insurers paid their proportionate share. The defendant insurer without denying liability to the mortgagor paid the mortgagee the amount of his judgment, which exceeded its proportionate share of the loss and took an assignment of the decree. *Held*, that the insurer, having failed to provide for contribution as to the mortgagee, was liable for the payment made and could not recover the excess from the mortgagor.

(For other cases, see Insurance, Cent. Dig. §§ 1509, 1515, 1516; Dec. Dig. § 606[2].)

2. INSURANCE—FIRE INSURANCE—RIGHT OF MORTGAGEE AND MORTGAGOR—LIABILITY—CONTRIBUTION.

The mortgagor could not recover from the insurer the difference between the face value of the policy and the amount paid the mortgagee; the liability to her having been discharged by payment of a greater amount than she herself could have recovered.

(For other cases, see Insurance, Cent. Dig. §§ 1502, 1503; Dec. Dig. § 604.)

Decision rendered, July 13, 1916. 98 Atl. Rep. 462.

Suit for injunction and other relief by Florence E. Palmer against John A. McFadden, guardian, the Niagara Fire Insurance Company, and others. Decree in part for complainant.

See, also, 97 Atl. 261.

Harry J. Weiner and William E. Reibel, both of Elizabeth, for Complainant.

Lindabury, Depue & Faulks, of Newark, for Defendants.

FOSTER, V. C.

The bill in this cause is filed to have the defendant the Niagara Fire Insurance Company enjoined from proceeding to collect any part of the amount due on a bond and mortgage made by the complainant to defendant, John A. McFadden as guardian, and on the decree entered in foreclosure proceedings thereon, and which bond, mortgage, and decree were duly assigned by McFadden to the Insurance Company. The bill also seeks to have this mortgage surrendered for cancellation, and also to compel the Niagara Fire Insurance Company to pay the complainant the difference between the amount of its insurance policy and the amount paid to the mortgagee when the bond, mortgage, and decree of foreclosure were assigned to it under the following circumstances:—

On March 11, 1911, complainant and her husband executed and delivered to the defendant John A. McFadden, as guardian, their bond, together with a mortgage on property in the city of Elizabeth, in this state, to secure the payment of \$3,500 and interest thereon.

In August, 1912, McFadden began foreclosure proceedings on this mortgage, and on December 18, 1913, he obtained a decree therein for \$3,225.

On October 17, 1912, the defendant the Niagara Fire Insurance Company issued its policy to complainant and one Sidney W. Eldridge, payable as their respective interests should appear, insuring the mortgaged premises against loss by fire in the sum of \$3,500. Attached to this policy was the standard mortgagee clause without contribution, by which loss, if any, under the policy was made payable to McFadden, mortgagee as his interest might appear. On December 2, 1912, the interest of Sidney W. Eldridge, in the policy, ceased.

The Scottish Union and National Insurance Company of Edinburgh, at this time, also had, in effect, a policy of insurance against fire covering said premises for the sum of \$6,000 and the Northern Insurance Company of New York also had, in effect, a policy of insurance covering said premises against fire for the sum of \$5,000, but neither of these policies were made payable to the mortgagee in the event of a loss.

On December 20, 1912, the insured dwelling of complainant was completely destroyed by fire.

Under the terms of the several policies, an appraisal was had and the sound value of the property was appraised at \$6,002.62,

and the loss from the fire was appraised at \$5,205.82. Of this loss the Scottish Union & National Insurance Company was compelled, by suit, to pay to complainant \$2,460 for its proportion of the appraised loss, and the Northern Insurance Company was also compelled by suit to pay complainant \$2,150 for its proportion of the loss.

The defendant the Niagara Fire Insurance Company, because of the mortgage clause attached to its policy, paid to the defendant McFadden, guardian, on his demand, \$3,416.67, being the amount of his decree and interest thereon, and took from him an assignment of the bond and mortgage and the decree in the foreclosure proceedings, and also an agreement subrogating the Niagara Fire Insurance Company to all the rights of McFadden as mortgagee.

The total amount of the insurance in force on the property at the time of the loss was \$14,500. The proportion the Niagara Fire Insurance Company would have to pay, except for the mortgagee clause, as its proportionate contribution towards the loss of \$5,205.82, is the sum of \$1,256.58; by reason of delay in making settlement of the loss, interest had accrued to the mortgagee, up to date of the assignment of the decree, amounting to \$131.58, making a total proportion of the loss for which the Niagara Fire Insurance Company admits liability of \$1,388.16; and the Niagara Fire Insurance Company claims that in making a settlement with the mortgagee under the policy and mortgagee clause for \$3,416.67, it paid him \$2,028.51 more than complainant would have been entitled to recover from it for its proportion of the loss.

The defendant Niagara Fire Insurance Company is now seeking to enforce the decree assigned to it (and which has been duly filed with the clerk of this court, and under which it has been substituted for McFadden, as complainant in the foreclosure suit) by the sale of the mortgaged premises to recover this alleged excess payment of \$2,028.50, with interest from the date of its settlement with the mortgagee, contending that by the terms of the policy and the mortgagee clause and by the assignment of the bond, mortgage, and decree of foreclosure it is entitled to be subrogated to the rights of the mortgagee to recover the amount it claims to have paid, in excess of the amount it was liable to pay, under its policy, to complainant as owner and mortgagor.

Complainant contends, however, that she is entitled to have the amount paid by the Niagara Fire Insurance Company to the mortgagee credited and applied in satisfaction of the debt secured by the mortgage, and to have the mortgage surrendered for cancellation, and that she is also entitled to have paid to her, by the Niagara Fire Insurance Company, the difference between \$3,500, the amount of the policy, and the amount of \$3,416.67 paid by the Niagara Fire Insurance Company to the mortgagee. There is no dispute regarding the liability of the Niagara Fire Insurance Company under the mortgagee clause to pay the mortgagee the amount of his claim.

The policy of the Niagara Fire Insurance Company contained the following provision:—

"This company shall not be liable under the policy for a greater proportion of any loss on the described property or for loss by any expense of removal from premises endangered by fire, than the amount hereby insured shall bear to the whole insurance, whether valid or not, or by solvent or insolvent insurers, covering such property, and the extent of the application of the insurance under this policy or of the contribution to be made by this company in case of loss may be provided for by agreement or condition written hereon or attached or appended hereto."

The mortgagee clause attached to this policy reads in part as follows:—

"Whenever this company shall pay the mortgagee (or trustee) any sum for loss or damage under this policy and shall claim that as to the mortgagor or owner no liability therefor existed, this company shall, to the extent of such payment, be thereupon legally subrogated to all the rights of the parties to whom such payments shall be made under all securities held as collateral to the mortgage debt, or may, at its option, pay to mortgagee with interest, and shall thereupon receive a full assignment and transfer of the mortgage and all other such securities; but no subrogation shall impair the right of the mortgagee (or trustee) to recover the full amount of their claim."

The questions to be determined are the extent of the liability, under its policy, of the defendant the Niagara Fire Insurance Company to the complainant, as owner and mortgagor, and its equity, if any, to be subrogated to the right of the mortgagee.

[1] The insurance company admits that, under the terms of the policy and mortgagee clause, it was compelled to pay the mortgagee the principal and interest of the debt due him, up to the amount of the policy, if necessary; but it insists that notwithstanding this liability to the mortgagee, it was only liable, by reason of the limitation imposed by the contribution clause of the policy to pay complainant, as owner, such proportionate share of her loss, that the amount of its policy bore to the total amount of insurance upon the premises, and that as it was compelled by the terms of the mortgagee clause to pay the mortgagee \$2,028.51 in excess of the amount for which it was liable to complainant, as owner, it is entitled to be subrogated to the rights of the mortgagee to the amount of such excess payment, and should be permitted to collect the same by a sale of the mortgaged premises, and, if necessary, by an action against complainant on her bond for any deficiency.

The situation presented is this: Complainant at her own expense procured insurance from the Niagara Fire Insurance Company, payable to herself and her mortgagee; the amount she could recover, from this company and each of the other insurers, in the event of loss, was limited by the contribution clause of the

policy, and the amount the mortgagee could recover was limited only by the amount of the debt due him and the amount of the policy.

The insurance company, in the language of the mortgagee clause, does not "claim that as to the mortgagor or owner no liability" for the payment made by it to the mortgagee existed. On the contrary it admits a total liability to the mortgagee, and also admits its liability to complainant, as owner or mortgagor, for its full contribution of the loss called for by the policy.

The rule governing the rights of the parties, under such circumstances, is stated as follows in 19 Cyc. p. 895, etc.:—

"If insurance is taken by a mortgagor for his own benefit or for the benefit of the mortgagee, or by the mortgagee in the mortgagor's interest and at his expense, payment of insurance money to the mortgagee goes to the benefit of the mortgagor in satisfaction pro tanto of the mortgage debt; but where the insurance is for the mortgagee's sole protection and the mortgagor has not procured it, or has lost the right to rely upon it, the company in paying to the mortgagee the insurance money, becomes entitled to equitable subrogation pro tanto to the security held by the mortgagee, and this right of subrogation is usually made a contract right by a provision in the policy that on the payment of loss under the policy the mortgagee shall assign his mortgage to the company in full or pro tanto as the case may be."

This rule has been followed in *Sussex Co. Mut. Ins. Co. vs. Woodruff*, 26 N. J. Law, 541; *Pearman vs. Gould*, 42 N. J. Eq. 4, 5 Atl. 811; *Nelson vs. Bound Brook Mut. Ins. Co.*, 43 N. J. Eq. 256, 11 Atl. 681, 3 Am. St. Rep. 308; *Hare vs. Headley*, 54 N. J. Eq. 546, 35 Atl. 445; *Leyden vs. Lawrence*, 78 N. J. Eq. 453, 79 Atl. 615.

From the facts stated it is apparent that neither of the requisites to entitle the insurance company to subrogation, viz., an insurance effected by the mortgagee at his own expense, or a denial of liability to the owner or mortgagor, is present in this case. The insurer by its contention is asking the court in effect to add a provision to the contract of insurance, which it neglected to impose when the mortgagee clause was attached to the policy; that is, it asks that a contribution clause be read into the mortgagee clause, limiting its liability thereunder as a similar clause limits its liability to the owner under the policy.

It is a matter of common knowledge that insurance companies issue the standard form of mortgagee clause both with and without the clause for full contribution from other insurers, and limiting liability thereby. In the present case the Niagara Fire Insurance Company saw fit to issue and to attach to complainant's policy the mortgagee clause, without the provision for contribution by other insurers, and without limiting thereby its liability for a greater proportion of any loss or damage sustained than the amount its policy bore to the whole amount of insurance upon

the property, whether such insurance was issued to or held by the owner or mortgagee, and it now asks the court by its contention to supply this omission from the mortgagee clause under consideration.

This, of course, cannot be done, and as complainant procured the insurance at her own expense, and as the insurance company does not disclaim, but admits liability to her as owner and mortgagor, she is entitled to have the amount paid the mortgagee credited in satisfaction of the mortgage debt, and to have the bond, mortgage, and decree of foreclosure surrendered for cancellation, but complainant is not entitled to have paid her the difference between the amount of the policy and the amount paid the mortgagee.

[2] The contract of insurance is a contract of indemnity. *Kase vs. Hartford Fire Ins. Co.*, 58 N. J. Law, 34, 32 Atl. 1057. By its payment to the mortgagee, in which payment was included the total amount for which the insurance company had agreed to indemnify complainant for her loss, the company has performed its obligation under the contract, set forth in the policy and in the mortgagee clause, and it is not liable for further payment to complainant, as the amount of such payment is beyond the amount for which it agreed to indemnify her.

A decree will be advised in accordance with the views herein expressed.

SUPREME COURT OF NEW YORK.

TRIAL TERM, NEW YORK COUNTY.

ADAMSON, CITY FIRE COM'R,

vs.

SCHREINER.*

1. INSURANCE — REGULATION — FOREIGN INSURERS — EXCLUSION.

The state may impose stringent conditions on foreign insurance companies incident to every transaction within its limits of the insurance business, and may even go so far as to exclude them altogether.

(For other cases, see *Insurance*, Cent. Dig. §§ 13, 14; Dec. Dig. § 18.)

2. INSURANCE—FOREIGN COMPANIES—LIABILITY—LICENSE FEES—"REINSURANCE."

Greater New York Charter (Laws 1901, c. 466) §§ 799, 800, respectively provide that there shall be paid to the Fire Commissioner, as treasurer of the fire department, by every person who shall act in the state of New York as agent for or in behalf of any individual or association

* Decision rendered, December, 1915. 160 N. Y. Supp. 745.

of individuals not incorporated by the laws of the state, to effect insurances, a percentage of the premiums, and that in each year a verified account shall be filed. Defendant was the agent of a foreign company doing business as reinsurer. Held, that since to allow defendant to escape on the ground that reinsurance did not fall within the purview of the charter would enable it to escape payment of most of its taxes, and as the word "reinsurance" from long usage has acquired a fixed meaning and is covered by the term "insurance," defendant was liable for the percentage.

(For other cases, see Insurance, Cent. Dig. §§ 16, 18-22; Dec. Dig. § 20.)

(For other definitions, see Words and Phrases, First and Second Series, Reinsurance.)

3. INSURANCE—FIRE INSURANCE—POLICIES—"AGENT."

The manager of a foreign insurance company, which writes reinsurance policies in this state, is agent within such provisions; the statute declaring that the term "agent" in the charter shall include an acknowledged agent or surveyor, or any person who shall in any manner aid in transacting the insurance business.

(For other cases, see Insurance, Cent. Dig. §§ 16, 18-22; Dec. Dig. § 20.)

(For other definitions, see Words and Phrases, First and Second Series, Agent.)

Action by Robert Adamson, as Fire Commissioner of the City of New York, against Carl Schreiner. Judgment for plaintiff.

Lamar Hardy, Corp. Counsel, of New York City (J. A. Stover, of New York City, of counsel), for Plaintiff.

William B. Ellison, of New York City, for Defendant.

COHALAN, J.

Plaintiff, as Fire Commissioner of the city of New York, brings this action for an accounting against the defendant as the agent of the Munich Reinsurance Company, a foreign corporation. If the plaintiff should succeed, the defendant would be required to account for all premiums which have been received by him, or by any person for him, or which have been agreed thus to be paid, for any insurance against loss or injury by fire in the city and county of New York, and, further, he would be required to pay to the plaintiff the sum of \$2 upon every \$100 upon the amount of all such premiums which directly or indirectly have been received by him as such agent. The suit was instituted pursuant to sections 799 and 800 of chapter 466 of the Laws of 1901 (Greater New York Charter, as amended). The statute reads as follows:—

"Sec. 799. There shall be paid to the Fire Commissioner as treasurer of the Fire Department, for the use and benefit of said fire department, on the first day of February, in each year, by every person who shall act in the city of New York, as agent for or on behalf of any individual or association of individuals, not incorporated by the laws of this state, to effect insurance against losses or injury by fire in the city of New York, although such individuals or association may be incorporated for that purpose

by any other state or country, the sum of two dollars upon the hundred dollars, and at that rate upon the amount of all premiums which, during the year ending on the next preceding first day of September, shall have been received by such agent or person, or received by any other person for him, or shall have been agreed to be paid for any insurance against loss or injury by fire in the city effected, or agreed to be effected, or promised by him as such agent.

"Sec. 800. Every person who shall act in the city as agent as aforesaid shall, on the first day of February, in each year, render to the Fire Commissioner as treasurer of the Fire Department a just and true account, verified by his oath, of all such premiums which, during the year ending on the first day of September preceding, shall have been received by him, or by any person for him, or which shall have been agreed to be paid for any such insurance effected, or agreed to be effected, or promised by him."

The plaintiff, under sections 808-12 of the charter, is directed to distribute the money collected by him from foreign insurance companies among "the trustees of the exempt firemen's benevolent fund of the city of New York." The money is used for the benefit of firemen's homes and the widows and orphans of deceased firemen.

It is the contention of the defendant (a) that the statute, practically construed, refers to insurers only and not to reinsurers; (b) that it does not by its terms apply to the agent of a reinsurance company, and that it may not be amplified by implication; (c) that to construe the section of the charter in question, as is contended for by the plaintiff, would result in double taxation; and (d) that the defendant is not an agent within the meaning of the provision of the charter in question.

The Munich Reinsurance Company has done a profitable business in the state of New York. In 1909 the company collected net premiums aggregating \$590,000; in 1912 it collected net premiums aggregating \$755,695; and it appears that the business done up to the commencement of the suit was constantly increasing. For the privilege of doing business in the city of New York it has paid nothing whatever to the city, and only one-half of 1 per cent of the premiums collected by it to the state. It would seem, therefore, that it has an unfair advantage over domestic companies, which pay 1 per cent to the state. The issues herein practically arise *de novo*, as the plaintiff and his predecessors have hitherto neglected to institute legal proceedings for the collection of the license fees provided in the statute to be paid by the agents of foreign insurance companies.

[1] That the state may impose stringent conditions upon foreign companies incident to the transaction within its limit of the business of insurance has long been the settled law of this state. *People vs. Fire Ass'n of Philadelphia*, 92 N. Y. 311, 44 Am. Rep. 380. In that case the court said:—

"The state, having the power to exclude foreign corporations, determines to do so unless they will submit to certain conditions. It meets the applicant on the border, forbidding admission, as it has a right to do, except on condition that it will fulfill all of the requirements of our statutes relating to foreign corporations, one of which is the very law here assailed. When the corporation comes in it agrees to the conditions. They become binding by its assent. The tax or license fee charged by the act of 1865 is one of these conditions. It is imposed as the price of permission to come within the jurisdiction, and not as a tax upon one already within the jurisdiction. * * * This view of the case renders of no importance the argument founded on the word 'tax,' and the distinction sought to be drawn between that and a license fee. Grant that it is properly denominated a tax, yet the payment of a specific tax may be imposed as a condition of assent to fire insurance within the state, and, as we have seen, has been so imposed by express and positive law."

This statute has already been construed and its manifest purpose has been set forth in the case of *Fire Department vs. Stanton*, 159 N. Y. 225, 54 N. E. 28. In that case the court said:—

"The obvious purpose of this legislation was to promote and to strengthen the development of domestic corporations, by removing the element of an unfair competition on the part of corporations, or associations, organized in other states; and an additional politic purpose may have been in the direction of a promotion of the safety of the citizen in insuring."

In another part of the well-considered opinion may be read:—

"It may be observed that the statute imposes, not exactly a tax, but a license fee, to be paid by those persons who, as agents, seek to build up a fire insurance business in the city of New York for principals who have not incorporated under the state laws."

[2] The first objection of the defendant to be considered is whether or not the charter provision embraces the term "reinsurance," as well as the term "insurance." The section reads that the agent shall pay "for any insurance against loss or injury by fire in the city effected or agreed to be effected or promised by him as such agent." It would seem that the word "any" is sufficiently broad to take in every form of insurance against loss or injury by fire, especially since the term "reinsurance" is defined to be a contract that one insurer makes with another to protect the first from the risk he has already assumed. *People ex rel. Continental Ins. Co. vs. Miller*, 177 N. Y. 521, 70 N. E. 10; *Imperial Fire Ins. Co. vs. Coos County*, 151 U. S. 452, 14 Sup. Ct. 379, 38 L. Ed. 231; *Matter of Western Assur. Co.*, 68 Fed. 708, 15 C. C. A., 619; *Hone vs. Mutual Safety Ins. Co.*, 3 N. Y. Super. Ct. 139; *London Assur. Co. vs. Thompson*, 170 N. Y. 99, 62 N. E. 1066. In the case of *People ex rel. Continental Ins. Co. vs. Miller*, *supra*, it is stated:—

"The word 'reinsurance,' as used in the statute (Tax Law

[Consol. Laws, c. 60] § 187), in so far as it applies to the relator, refers to the premiums received by it for reinsuring the risks of other companies. The test here, the same as in the first question discussed, is the business done by the company in using the privilege for which the tax is imposed. When it causes its own risks to be reinsured by another company it is not, so far as that act is concerned, doing an insurance business; but when it reinsurance the risks of other companies it is doing an insurance business, and should, according to the statute, be taxed for the privilege."

In that case it was held that the relator, a domestic fire insurance corporation, under section 178 of the Tax Law, was required to pay to the state 1 per cent per annum on the gross amount of the premiums collected, and that the sum paid to other companies for reinsuring its own risks should not be deducted from such amount. It has been further held in the case of *Hone vs. Mutual Safety Ins. Co.*, *supra*, as follows:—

"In this instance the word 'reinsure' has a definite meaning, settled in the law for two centuries past, and having the same meaning in its ordinary and popular sense. It is equally effective with the word 'insure,' and it has been decided that 'insure' may be used in a policy of reinsurance with the same force and validity. * * * When the insurer for some reason finds it convenient that another shall bear either in whole or in part the liability to the insured which he has assumed, and agrees with another to assume the whole or part of his liability with reference to the insured, it is termed a contract of reinsurance."

I am disposed to hold that the word "insurance" has no narrow or restrictive meaning, and that it takes in any form of fire insurance; to hold otherwise would be in effect to defeat the purpose of the statute.

The defendant further claims that the section of the charter does not by its terms apply to the agent of a reinsurance company, and providing for a tax, as it does, that it may not be amplified by implication. But it has been held that the statute imposes, not precisely a tax, but a license fee, to be paid by those persons who as agents seek to build up the fire insurance business in the city of New York for principals who have not incorporated in this state. *Fire Dept. vs. Stanton*, *supra*. Moreover, the statute should be construed with reference to the purpose of the Legislature in enacting it; that purpose was to strengthen the development of domestic corporations engaging in the business of fire insurance in this state, and to remove therefrom unfair competition on the part of corporations or associations organized in other states. A statute is to be construed so as to give it an interpretation not inconsistent with the purposes of the act. *The Emily and the Caroline*, 9 Wheat. 381, 6 L. Ed. 116; *Hubbard vs. Brainard*, 35 Conn. 563.

Under section 187 of the Tax Law a domestic fire insurance company must pay to the state an annual tax of 1 per cent on all

premiums of insurance and reinsurance, while foreign fire insurance companies pay to the state but five-tenths of 1 per cent on all premiums of insurance and reinsurance, in addition to all other fees, licenses, or taxes imposed by that or any other law. If the defendant's contention be sound, that under the provisions of section 799 of the charter no tax or license fee is to be paid to the city of New York by the agents of foreign fire insurance companies on policies of reinsurance, the purpose of the statute would be defeated. It is significant that under section 187 of the Tax Law there is this provision:—

"The taxes imposed by this section shall be in addition to all other fees, licenses or taxes imposed by this or any other law. * * *"

Nor would a construction of section 799 of the charter, as claimed by the defendant, result in double taxation. In *People vs. Home Ins. Co.*, 92 N. Y. 328, it was held that the Legislature may, in its discretion, impose unequal or double taxes. The court, at page 347, said:—

"In performing the duty of levying taxes for the support of government, state Legislatures may, in the exercise of their undoubted power, impose double taxes or lay burdens beyond the financial capacity of the classes taxed, and, however impolitic or unwise such a course would be, the courts have no right to interfere with the exercise of the legislative discretion [citing cases]. Such questions properly belong to the legislative branch of the government, whose exclusive duty it is to apportion and impose the taxes required for the use of the government."

[3] Finally, with respect to the question of agency, I think, there is no doubt that the defendant was the agent of the Munich Reinsurance Company within the meaning of the statute. It reads:—

"The term 'agent' in this chapter shall include an acknowledged agent or surveyor or any other person who shall in any manner aid in transacting the insurance business of any insurance corporation not incorporated by the laws of the state, and any broker whose business, in whole or in part, is to negotiate for and place risks, deliver the policies covering the same and collect premiums therefor."

In the case of *Fire Department vs. Stanton*, supra, the defendant claimed that he was the general manager of the "American Lloyds," and that he did not effect or receive premiums. He claimed that they were effected through brokers, and the premiums therefor were paid to the underwriters. He was sued for a percentage of the premiums received by him under section 799 of the Greater New York Charter. In its opinion the court said:

"But this objection is disposed of by the finding of the trial judge that the defendant acted as agent for the association of underwriters in question and received premiums for effecting insurance. This finding is not only justified by the evidence, but

partly by the averment in the answer that 'as general manager and attorney in fact * * * he has received premiums of insurance effected on property in the city of New York.' "

The defendant herein testified that he was the United States manager of the Munich Reinsurance Company and the sole representative of that company in the United States, except a board of trustees, who had nothing to do with the transaction of the general business of the company; that he maintained an office in the city of New York; that he negotiated with the representatives of direct insurance companies and agreed with them upon the terms that were placed in insurance contracts or treaties; that he signed them as manager; that he did many other acts which unquestionably indicate that he was the agent of the Munich Reinsurance Company, and effected policies of fire insurance in behalf of that company in the city of New York.

I am satisfied, in conclusion, that the statute in question should be construed so as to require the agents of foreign fire insurance companies to pay the percentage provided on all policies of reinsurance as well as on all policies of direct insurance. By such construction the purposes of the act would be fulfilled and the intention of the Legislature to discriminate against foreign companies would be established.

Judgment for the plaintiff for an accounting, as demanded in the complaint.

Judgment for plaintiff.



SUPREME COURT OF APPEALS OF VIRGINIA.

CONNECTICUT FIRE INS. CO.

vs.

W. H. ROBERTS LUMBER CO.*

1. INSURANCE—FIRE POLICIES—CONSTRUCTION.

A fire policy, insuring lumber and staves owned or held in trust or commission by plaintiff, while stacked or piled at its various mill sets or yards or shipping points, does not extend to plaintiff's profits which might result from its handling of lumber.

(For other cases, see Insurance, Cent. Dig. § 1283; Dec. Dig. § 507.)

Error to Circuit Court, Wise County.

Action by the W. H. Roberts Lumber Company against the Connecticut Fire Insurance Company. From a judgment for plaintiff, defendant brings error. Reversed.

* Decision rendered, Sept. 11, 1916. 89 S. E. Rep. 945.

Morison, Morison & Robertson, of Big Stone Gap, for Plaintiff in Error.

E. M. Fulton, of Wise, and Chapman, Peery & Buchanan, of Tazewell, for Defendant in Error.

SIMS, J.

In this case the judgment complained of in favor of the appellee, plaintiff in the court below, against appellant, defendant in the court below, was obtained upon a fire insurance policy, referred to in the record as a "floating policy," being what is designated by text-writers on the subject as an open, floating, or blanket policy, and the judgment was for the amount of the plaintiff's expected profits in certain lumber, which lumber was covered by the policy.

There are four assignments of error, but in the view we take of the case we need consider only one inquiry, and that is:—

[1] (1) Did the policy sued on cover the profits of the plaintiff in the lumber in question?

The material parts of the policy sued on are as follows:—

"No. 1055.

"The Connecticut Fire Insurance Company of Hartford,
"State of Connecticut,

"Amount \$8,000.00.

"Rate \$1.50. Premium \$120.00.

"In consideration of the stipulations herein named and of one hundred and twenty dollars premium, does insure W. H. Roberts Lumber Company for the term of one year from the twenty-fourth day of June, 1913, at noon to the twenty-fourth day of June, 1914, at noon against all direct loss or damage by fire, except as hereinafter provided, to an amount not exceeding eight thousand dollars, to the following described property while located and contained as described herein, and not elsewhere, to wit:—

"W. H. Roberts Lumber Co.

"\$8,000.00 on lumber, staves and timber products of every description now owned or which may be hereafter manufactured, or held in trust or on commission, or sold but not delivered or removed, or lumber, staves and timber products of every description on which advances are made under contract of purchase, while stacked or piled at various mill sets or yards, or at shipping points, in the counties of Wise and Lee, state of Virginia.

* * * * *

"It is understood and agreed that the amount insured by this policy shall attach in each of the above-named premises in that proportion of the amount hereby insured that the value of the property covered by this policy contained in each of the said places shall bear to the value of such property contained in all of the above-named premises.

"* * * Lightning, iron safe * * * clauses attached.

"Attached to and forming part of policy No. 1055 of the Connecticut Fire Insurance Company of Hartford, Conn.

"Virginia-Kentucky Insurance Corporation,

"By R. L. Kilgore, Sect., Agents."

"Lightning Clause."

"It is hereby specifically agreed that this policy insures against any loss or damage caused by lightning to the property insured, not exceeding the sum insured, nor the interest of the assured in the property. * * *

It is clear from a reading of the policy itself that it does not insure profits. The terms used in the policy defining the subject of the insurance are those which have a well-settled meaning, and contract, in effect, to insure the interests of the plaintiff of whatever character in the lumber itself, existing at the time of the loss by fire, and not profits which might arise from the dealing of the plaintiff with such lumber.

The character of the contract of insurance of property, or an interest or interests in property itself, is very different from a contract of insurance of profits to arise from the dealing with such property. The former is an indemnity against loss of existing property interests, at the time of the loss by fire; the latter is an insurance of expected interests, at the time of the loss by fire, viz. profits. The former concerns what is in actual existence, the latter what is only potentially in existence. And the text-writers and decisions of the courts seem to be uniform in their expression of the rule that a policy of insurance will not be held to cover profits unless the purpose to do so is expressly stated in the policy. The difficulty is not that profits may not be insured. They may. It is solely a question of what in fact is the contract of insurance.

The following named text-writers have this to say on the subject of profit insurance:—

"Expected profits may be insured, both in this country and in England. * * * But the insured must have an interest in the property out of which the profits are expected to proceed, and the profits must be insured as profits. * * * And such expected profits are still insurable, though the insured may have no absolute ownership in the property out of which the profit are expected to arise, but merely a right, if he should so elect, to take it on certain terms and conditions in a certain event. * * *" 1 May on Ins. § 79, citing a number of cases.

"An insurance may be validly made on profits. Profits should be specifically described, whether the property be insured under a marine or fire risk, and this rule is unquestionably the law in England. Lloyd's form of policy is adopted as usual by the insertion of the words 'profits' or 'commissions' in the margin, or in the valuation clause, adopting or adapting the language of the

clause according as the subject of the insurance is valued or not." 2 Joyce on Ins., § 1760, citing a number of English and American cases.

"It may be stated as a rule that if profits are not specially insured they cannot be recovered as such." 3 Id., § 2806, citing a New York case.

"While the subject-matter of insurance and the nature of the risk should be properly described in the policy, neither the nature nor extent of the interest need, as a general rule, be specifically set out therein. * * * It is held that in certain cases the nature or character of the interest may be such as that a special description is required. Thus it seems that profits must be insured as such." 2 Id., § 900, citing a number of American cases.

See, also, 19 Cyc. 840, and cases cited.

Counsel for plaintiff in their brief, in effect, admit that this rule is applicable, and that if the policy sued on is looked to alone, it does not insure profits, but they take the position that "the intent of the parties was to give the insured valid insurance upon whatever interest he had or might have, under contracts of purchase or otherwise," in the lumber in question, and they cite the following authority:—

"Intention to be Taken into Account."—Policies should be construed so as to give effect to the evident intention of the parties.

"Liberal Construction in Favor of Insured."—The policy of insurance, being an instrument prepared by the insurer, should, in case of doubt under the general rules, be construed strictly against the insurer who prepared it, and liberally in favor of the assured. This is the rule, even though the intention of the company is otherwise." 19 Cyc. 656-7.

In a note, page 656, this language appears:—

"If there is any doubt or uncertainty under the terms of the policy as to the intent of the parties, it is to be resolved in favor of the insured."

And counsel for plaintiff refer to the testimony on this point of the plaintiff, Mr. Roberts, and of Mr. Fulton, former general manager of the corporation which was the insurance agent which solicited and first placed the insurance for plaintiff in the form of a floating or blanket policy with the defendant, which insurance was afterwards renewed through the same agent acting by another general manager, Mr. Kilgore, and the policy sued on issued by the latter. The testimony of Mr. Roberts and Mr. Fulton, referred to, is as follows:—

Mr. Roberts testified:—

"Q. Did the insurance agent at the time of the issuance of this policy understand your situation and the purpose for which you were taking the policy?

* * * * *

"A. Yes; it was thoroughly gone over by him and discussed

that this floating policy would take care of any interest I bought or had in lumber in the two counties. I paid more for it, a higher premium, as I understood, to get it—I had so many yards. If I had not understood it that way, I positively would not have taken the policy, because it would have been worthless to me."

W. H. Roberts (recalled for further cross-examination) further testified as follows:—

"By Mr. Irvine:—

"Q. Mr. Roberts, you referred in your former examination to a conversation you had with an insurance agent in which you understood all your interests in this lumber were covered before this policy was issued. Who was that agent?

"A. It was Claude Fulton. The first talk I had was with Mr. Hurt on the train is my remembrance of it, and then I was taking all my insurance with the agency here at Wise, Virginia-Kentucky, and Claude Fulton was solicitor, and I took it up with him.

"Q. Mr. Hurt did not represent the Connecticut Fire Insurance Company?

"A. No, sir; not that I know of.

"Q. Did Mr. Claude Fulton, or the agency he represented, represent the Connecticut Fire Insurance Company?

"A. At that time I could not state.

"Q. When was that?

"A. To the best of my opinion, it was either in 1911 or 1912.

"Q. You do not claim to the jury that it was at the time this policy now sued on was taken out, or the one referred to here of the year preceding?

"A. I don't know that it was. I depended on the agency giving me the same policies, renewing them, as was first given me, we first took out. As to looking at each one of the policies, I don't remember how it was, whether there was anything said about the policies after we got what they called a 'floating policy.'

"Q. Did you ever have a floating policy in any other company except the Connecticut Fire Insurance Company?

"A. Yes; I think they gave me one in some others first.

"Q. You had several others?

"A. I don't remember how many. For each year I took a policy for \$8,000; I think they put it in two companies.

"Q. Did you not have a policy in one or two companies in which the words 'all your interest' were written in its typewritten part of the policy?

"A. Yes; after looking at the policy I noticed it was in there. I supposed it was in this policy; I supposed the policies were all the same.

"Q. Wasn't one or more of these policies subsequently canceled on you because of the words 'all your interest,' or 'their interest' appearing in it?

"A. No, sir; if ever a policy was canceled for that, it was not brought to my attention; I have no recollection of it. Sometimes they would come to me and say that they were going to put it in another company, but I left it to be the Wise, Virginia agency. I thought they were all about the same, and I had no choice as to what company I got it in, and why they did it I didn't know."

Mr. Fulton testified:—

"Q. While you were manager of that agency, did you have any conversation with Mr. Roberts about a 'floater policy' on his lumber yards?

"A. Yes.

"Q. What?

"A. I had written Mr. Roberts some insurance; he had given us all his insurance business, and I had written him policies on shorter periods than one year, sixty or ninety days, sometimes four months on certain yards of lumber; I had been doing that, and I suggested to Mr. Roberts that a better plan would be take out a floating policy covering all the interest he had in lumber and let him have it all in one policy. I told him I had talked the matter over with Mr. Hurt. Mr. Hurt was pretty well up on insurance business, and he informed me that such a policy could be written, and I looked it up, and I thought so too myself; that he could get a policy covering any interest he had in any lumber he might buy; he would buy lumber and take a policy of insurance on it, and sometimes we would put a 'loss payable clause' in it payable as interest appeared, and I told him I thought he would save money by taking a policy and carrying it year in and year out, a blanket policy.

"Q. Was there any conversation passed between you as to any policy covering all his interest and profits, or anything like that?

"A. All his interests were covered. That was the intention of the policy I told him we could write. The word 'profits' was not mentioned in it.

"Q. Did you in fact write him a policy with all his interest appearing in it?

"A. Yes; I think so.

"Was that canceled?

"A. I think I have that record here somewhere (witness looks at papers). On January 13, 1912, I issued two policies to Mr. Roberts; that was the first time I undertook to issue to him policies for a year, for \$4,000 each in that form.

"Q. What is that form?

"A. Policy No. 60120 in German Alliance Insurance Association, policy No. 397348 in Globe-Rutgers Fire Insurance Company, issued January 13, 1913. Then on February 10, 1912, I issued policy No. 307307 in the Monongahela Underwriters Agency to take the place of policy No. 60120 in the German Alliance, and afterwards took up policy No. 307307 in the Monon-

gahela and wrote policy No. 307315 in the Monongahela Underwriters, covering the whole thing, placing the whole thing with them. That went on about three months, and I canceled that policy and rewrote the policy for \$8,000 in the Connecticut Fire Insurance Co.

"Q. When was that written?

"A. June 24, 1912.

"Q. Have you the form of that policy there?

"A. Yes.

"Q. When did the Connecticut Fire Insurance Company first come into your office?

"A. I don't remember the exact date.

"Q. This was the first policy in June, 1912, that you wrote with them in connection with Roberts?

"A. My recollection is they had only been with us a short while when I wrote that policy.

"Q. The Globe-Rutgers and German Alliance and Monongahela all seem to read 'On lumber, staves and timber products of every description, their interest in lumber, staves, and timber products of every description, now owned or held in trust, or on commission, or sold, but not delivered, or removed, while staked or piled at various mill sets or yards, or at shipping points, in the county of Wise, Lee, Dickenson, and Scott, state of Virginia.' Is that correct?

"A. That is the way I remember it.

"Q. I will ask you to look at the memoranda which you handed me and state if I read it correctly?

"A. Yes; that is correct.

"Q. Were these policies canceled that you just referred to as having been written in the Globe & Rutgers, German Alliance, and Monongahela Underwriters?

"A. Yes; the Globe & Rutgers canceled because I exceeded their line they would accept on lumber—I really didn't do it—but that was the reason they gave for canceling; and, as well as I remember, German Alliance canceled also.

"Q. Why did they cancel?

"A. I do not remember, but my impression is lumber losses had been rather heavy in this section up to that time, and the companies begin to get kind of scared of them; I know several of the companies were.

"Q. Why did the Monongahela cancel?

"A. I think the Monongahela had a loss under that policy, and when we settled that loss—they perhaps had another loss here—they canceled that policy, and I believe withdrew from this territory; that is my remembrance, but I am not so positive of that.

"Q. Now, I ask you to examine the memoranda just handed me

as covering what was insured by the Connecticut Fire Insurance Company under their policy of June, 1912, and state if that is any different in the contracting clause from the policy sued on in this case, or, rather, I will read it to you: 'On lumber, staves, and timber products of every description now owned, or which may be hereafter manufactured or held in trust, or on commission or sold but not delivered or removed, while staked or piled at various mill sets or yards, or at shipping points in the counties of Wise and Lee, state of Virginia.'

"Mr. Fulton: That don't cover it. Here is the policy itself.

"Mr. Peery: On which advances are made under contract of purchase.

"Q. (continued.) The clause I have just read is the same as the other, except the other clause includes 'on which advances are made under contract of purchase,' is it not?

"Mr. Peery: The policy speaks for itself.

"A. I did not have anything to do with the last policy.

"Mr. Peery: Are you asking if they are the same? They are not the same.

"Q. The point I want to get at is this: It does not contain the words 'interest in lumber'?

"A. No, sir.

"Q. Did you have at any time a discussion with Mr. Roberts about whether or not it covered his entire interest in lumber, this Connecticut Fire Insurance policy?

"A. As I stated, I could not say how it came about. My idea was, as I had talked to Mr. Roberts to insure his interest in lumber under that blanket policy, that he would buy at various places around, and the lumber he had at mill sets, and that would do away with the issuing of so many policies and the making of so many entries on my register.

"Q. When was that talk you had with Mr. Roberts; do you remember?

"A. Well, I talked it over with him various times.

"Q. Do you know whether you had any such talk with him at the time you issued the Connecticut Fire Insurance policy?

"A. I could not say.

"By Mr. Morison:

"Q. Mr. Fulton, do you know what date you began doing business for the Connecticut Fire Insurance Company as agent?

"A. I could not state, but evidently a short time before this policy No. 1006 was issued; had only issued five policies before that. This was the sixth policy.

"Q. I believe you stated that you sold out your interest in the agency in December of that same year?

"A. Yes.

"Q. And had no further connection with the agency after the first of the year?

"A. No, sir.

Cross-examination:

"By Mr. Peery:

"Q. Mr. Fulton, the Virginia-Kentucky Insurance Corporation was the local agent for a number of fire insurance companies, was it not?

"A. Yes; I think we had four or five at this time, perhaps six.

"Q. As I understand you, Mr. Roberts had been taking these short-term policies covering his interest in lumber manufactured by him, or upon which he had contracts of purchase, and these policies cost more than the longer term policies?

"A. They were taken at the short rate.

* * * * *

"Q. He discussed the matter with you and explained to you his situation, how he was buying lumber, how he was manufacturing it, and you advised him that you could give him a blanket contract covering insurance on his interests in the lumber manufactured or bought by him?

"A. Well, we talked it over numbers of times, I don't remember the exact conversation, but that was my idea and his idea too, as I gathered from what he said. I think one time Mr. Hurt was over there when we discussed, and I think I asked him if that would cover it, this form, and I think he said that was about the form other agencies used.

"Q. Other dealers in lumber situated like Mr. Roberts?

"A. I think that was just the conversation.

"Q. Mr. Roberts left it to your agency as to what company or companies you would place his insurance in?

"A. Yes, invariably did. We did all his insurance business practically, and placed it in any company that we wanted to, and I never did hear any kick about it.

* * * * *

"Q. Now, Mr. Fulton, the Virginia-Kentucky Insurance Corporation was authorized to issue and deliver policies without sending them in to the company, was it not; in other words, when a man applied to you for insurance, you would simply take a blank from of policy and sign it as agent and deliver the policy?

"A. Yes.

"Q. You had authority to do that from the companies you represented?

"A. Yes.

"Q. You had such authority from the Connecticut Fire Insurance Company?

"A. Yes.

"Q. This policy which delivered on behalf of the Connecticut Fire Insurance Company, that is, the first one, was delivered by you to Mr. Roberts with the idea of insuring all of his interest

in lumber manufactured by him or upon which he had contracts. Is that correct?

"A. Well, my idea was to issue a blanket policy so as to cover the lumber at his mill sets, various places in the country, as I have told you about how it was done.

"By Mr. Morison:

"Q. When you issued and delivered a policy as described by Mr. Peery, did you or not have to send a copy of the part you filled in to the company?

"A. Yes.

"Q. Was that a matter of daily reports?

"A. Yes, As well as I remember we had a typewritten form, and we would make three copies, one for the agency, one for the company, and one for the policy.

"Q. If the company did not approve of the form you wrote up, what would it do?

"A. Well, I don't know so much about the form, but if they didn't want the insurance on the property, they would request us to cancel it; if they didn't like the form, they would request that we change the form.

"By Mr. Peery:

"Q. You say you placed this insurance in the Monongahela, and then you placed it in the Connecticut. Were you endeavoring to follow the same form that you had in the policy that was first issued for Mr. Roberts?

"A. I could not say positively about that, because I have no distinct remembrance. I see that I did not follow it, but I don't remember why it was now. I tried to find the correspondence about it before that, but my brother and Mr. Kilgore destroyed all the correspondence we had before 1912 about the matter, and I could not find it to refresh my memory about it, and I could not say about that."

Mr. Kilgore testified on the subject as follows:

"By Mr. Irvine:

"Q. Mr. Kilgore, did you become manager of the Virginia-Kentucky Insurance Corporation January 1, 1913?

"A. I did.

"Q. Did you write the policy sued on for that agency on behalf of Mr. Roberts in this case?

"A. I did.

"Q. Was there ever any talk between you and Mr. Roberts about what this policy covered, either the one sued on or the one for the year preceding this, 1913-1914?

"A. Not that I think of. A few days before that policy expired I gave him the usual notice, and asked him to renew the policy, and he requested the renewal, and in renewing the policy I copied the form from the policy for the year preceding it, the only difference being the date of expiration.

"Q. The one sued on is a copy of the one for the year preceding?

"A. Yes."

[2] The general rule in Virginia on the subject of the admissibility of parol evidence upon the construction of policies of insurance is well settled:—

"Insurance Contracts—Construction.—The same rules of construction which apply to other contracts apply to these. The policy is to be construed according to its terms. There can be no resort to parol evidence except in case of latent ambiguity." *Home Ins. Co. vs. Gwathmey*, 82 Va. 923, 1. S. E. 209.

[3] But if the parol evidence in this case were admissible on the ground that the policy sued on was prepared by the agent of the defendant and by mistake was written differently from the contract of insurance, as in fact made by the plaintiff and such agent, so as to raise an equitable estoppel against the insurance company which may be effectually asserted by the insured in a court of law, under the doctrine of *Medley vs. German*, etc., *Ins. Co.*, 55 W. Va. 342, 47 S. E. 101, 2 Ann. Cas. 99—which question, however, we do not mean to decide, because not necessary for the decision of the case at bar—still if the utmost effect were given to the evidence in behalf of the plaintiff, under the rule applicable upon a demurrer to evidence, the parol evidence in this case does not show that there was a meeting of the minds both of the plaintiff and defendant (the latter acting through its agent) with respect to the contract of insurance, beyond the intention that the policy of insurance should insure against all loss or damage by fire "any interest" the plaintiff "bought or had in the lumber" in question at the time of its destruction by fire. No "profits" were at any time mentioned, or, so far as the record shows, were ever considered or thought of by the plaintiff or the agent of the defendant, prior to the loss by fire. Even if the policy sued on had contained the language, "any interest in lumber," etc., along with the other language in the policy designating the subject of the insurance, it could not be construed to cover expected profits. For the policy to cover the latter, it must expressly appear therefrom that profits were insured.

[4] Such being our view of the case, and the evidence showing that the plaintiff could have sustained no loss by the fire except expected profits, so that no new trial could avail the plaintiff anything, this court will set aside the verdict and reverse the judgment complained of, because there is no evidence in the case to sustain it, and will enter such judgment as the court below should have entered, dismissing the plaintiff's action.

Reversed.

Cardwell, P., absent.

FIREMEN'S INS. CO. vs. LAREY. (Nos. 109, 142.)*
(Supreme Court of Arkansas.)

2 INSURANCE—FORFEITURE—CHANGE OF INTEREST—SALE BY PARTNER.

Where an insurance policy covering partnership property is voidable by change of title of insured, a sale of his interest by one partner to a third person affects the risk, because a new party is brought into contractual relations with the insurance company.

(For other cases, see Insurance, Cent. Dig. §§ 805-808; Dec. Dig. § 328[9].)

3. INSURANCE—FORFEITURE—CHANGE OF INTEREST—SALE BY TENANT IN COMMON.

Under such policy covering property of tenants in common, a sale by a tenant in common of his interest to a stranger ends the contract of insurance as to him or his vendee.

(For other cases, see Insurance, Cent. Dig. §§ 795, 798, 813, 814, 818-822; Dec. Dig. § 328[2].)

4. INSURANCE—FORFEITURE—CHANGE OF INTEREST—SALE BY TENANT IN COMMON.

Under such policy, covering property of tenants in common, a sale by a tenant in common of his interest to a stranger does not affect the insurance as to the remaining tenant or tenants in common, since thereby no stranger is brought into contractual relation with the insurance company so far as concerns that part of the insurance which covers the interest of the tenant or tenants in common not selling.

(For other cases, see Insurance, Cent. Dig. § 825; Dec. Dig. § 328[15].)

Appeal from Circuit Court, Miller County; Geo. R. Haynie, Judge. Action by R. L. Larey against the Firemen's Insurance Company. From a judgment for plaintiff, defendant appeals. Affirmed.

Webber & Webber, of Texarkana, for Appellant.
J. M. Carter, of Texarkana, for Appellee.

* Decision rendered, July 3, 1916. 188 S. W. Rep. 7.



FERRAR vs. WESTERN ASSUR. CO. (Civ. 1481.)*
(District Court of Appeal, First District, California.)

1. INSURANCE—RISK—PAROL CONTRACT—SUFFICIENCY OF EVIDENCE.

Evidence, in an action to recover the amount of a fire insurance policy issued upon certain furniture, held to sustain a finding that the property was covered by a parol contract of insurance at the time of the fire.

(For other cases, see Insurance, Cent. Dig. § 1709; Dec. Dig. § 665[2].)

* Decision rendered, May 18, 1916. Rehearing denied by Supreme Court, July 17, 1916. 159 Pac. Rep. 609.

2. INSURANCE—AGENCY FOR INSURED—AUTHORITY.

The direction of the owner of furniture to an insurance broker to place insurance for her, and take care of her insurance and see that she was covered to a certain amount constituted the broker a general agent to keep her insured in such amount.

(For other cases, see Insurance, Cent. Dig. § 126; Dec. Dig. § 96.)

3. INSURANCE—AGENCY FOR INSURED—POWER.

A general agent to keep one insured to a certain amount was authorized, as an incident of his employment, to accept and act upon a notice of cancellation of a policy, and to procure insurance in another company. (For other cases, see Insurance, Cent. Dig. § 503; Dec. Dig. § 229[3].)

4. INSURANCE—AGENCY FOR INSURED—RATIFICATION AFTER LOSS.

A ratification of the action of an insurance broker in procuring a policy for the insured, though made subsequent to a loss, is valid.

(For other cases, see Insurance, Cent. Dig. § 134; Dec. Dig. § 112.)

5. INSURANCE—AGENCY FOR INSURED—RATIFICATION.

Insured, by filing her claim of loss and demanding payment, thereby ratified the action of her broker in accepting a notice of the cancellation of a policy and in procuring a policy in defendant, another company.

(For other cases, see Insurance, Cent. Dig. § 134; Dec. Dig. § 112.)

Appeal from Superior Court, City and County of San Francisco; Geo. A. Sturtevant, Judge.

Action by H. M. Ferrar against the Western Assurance Company. Judgment for plaintiff, motion for new trial denied, and defendant appeals. Judgment and order affirmed.

Rehearing denied in Supreme Court, 159 Pac. 611.

J. F. Riley, of San Francisco, for Appellant.
Bacigalupi & Elkus and Jewel Alexander, all of San Francisco, for Respondent.

**ROYAL EXCH. ASSUR. OF LONDON, ENGLAND, vs. GILMORE.
(No. 6862.)***

(Court of Appeals of Georgia.)

INSURANCE—FIRE INSURANCE—ACTIONS—RECOVERY.

The petition as amended shows an absolute breach of the "iron safe clause" by the insured after the policies were completed by attaching the same thereto, and consequently the court erred in overruling the demurrer and refusing to dismiss the petition. All after proceedings were nugatory and therefore need not be considered.

(For other cases, see Insurance, Cent. Dig. § 853; Dec. Dig. § 335[4].)

Error from City Court of Ashburn; R. L. Tipton, Judge.

* Decision rendered, Sept. 16, 1916. 89 S. E. Rep. 1047. Syllabus by the Court.

Action between R. C. Gilmore and the Royal Exchange Assurance of London, England. There was a judgment for the former, and the latter brings error. Reversed.

Smith, Hammond & Smith, and King & Spalding, all of Atlanta, and Whipple & McKenzie, of Cordele, for Plaintiff in Error.

Jno. B. Hutcheson, of Ashburn, and J. T. Hill and F. G. Boatright, both of Cordele, for Defendant in Error.



**ALMA GIN & MILLING CO. ET AL. vs. PEEPLES ET AL.
(No. 626.)***

(Supreme Court of Georgia.)

INSURANCE—FIRE INSURANCE—STATUTES—APPLICABILITY.
The act of August 17, 1906 (Acts 1906, p. 107), is not applicable in a case where suit is brought by one or more policyholders to establish the liability of other policyholders to pay assessments, and to compel them to contribute to the payment of losses sustained by the complainants.

(For other cases, see Insurance, Cent. Dig. § 89; Dec. Dig. § 64.)

Error from Superior Court, Clarke County; C. H. Brand, Judge.

Petition by Williams and Moore against an insurance company, in which W. J. Peeples was appointed receiver, and the Alma Gin & Milling Company and others intervened. There was a judgment against the Alma Gin & Milling Company and others, and they bring error. Affirmed.

Holden, Shackleford & Meadow, of Athens, for Plaintiffs in Error.
Griffiths & Matthews, of Buchanan, J. H. Williams, Max Michael, Cobb, Erwin & Rucker, E. K. Lumpkin, E. K. Lumpkin, Jr., Green & Michael, Wolver M. Smith, H. C. Tuck, H. S. West, and S. C. Upson, all of Athens, W. W. Stark, of Commerce, and J. H. Felker, of Monroe, for Defendants in Error.

* Decision rendered, Aug 22, 1916. 89 S. E. Rep. 820. Syllabus by the Court.

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**LIVERPOOL & LONDON & GLOBE INS. CO., LTD., vs.
HUGHES. (No. 623.)***

(Supreme Court of Georgia.)

1. INSURANCE—FIRE INSURANCE—BURDEN OF PROOF.

Where a policy of fire insurance contained a clause that, unless otherwise provided by agreement indorsed thereon, it should be void if the insured then had or procured other insurance on property covered in

* Decision rendered, Aug. 22, 1916. 89 S. E. Rep. 817. Syllabus by the Court.

whole or in part by such policy, if it be shown that at the time of the issuance of such policy the insured had other insurance on the property, but the insured should seek to avoid the effect of such clause by setting up a waiver thereof, the burden of showing such waiver would rest on the insured thus asserting it. Civ. Code, 1910, § 5746; 7 Encyc. Ev. 539.

(For other cases, see Insurance, Cent. Dig. § 1658; Dec. Dig. § 646[5].)

3. INSURANCE—FIRE INSURANCE—POLICIES.

Whatever may have been ruled in other jurisdictions, in this state the point is concluded by former decisions that, where a policy of fire insurance contains a clause that, unless otherwise provided by agreement indorsed upon it, it should be void if the interest of the insured be other than the unconditional and sole ownership, or if the subject-matter of insurance be a building on ground not owned by the insured in fee simple, the fact that the insured held under a bond for title at the time when the insurance was effected would not alone be sufficient to answer the requirements of such a clause. Orient Ins. Co. vs. Williamson, 98 Ga. 464, 25 S. E. 560, *supra*; Williamson vs. Orient Ins. Co., 100 Ga. 791, 28 S. E. 914; Athens Mutual Ins. Co. vs. Ledford & Son, 134 Ga. 500, 68 S. E. 91; Atlas Assurance Co. vs. Kettles, 144 Ga. 306, 87 S. E. 1.

- (a) We have been requested to review and reverse these rulings (except the last case cited, which was decided by five justices); but the requisite number of justices do not concur in so doing, and such decisions must stand.
- (b) The question whether a vendee in possession who has fully paid the purchase money would be such an owner as to meet the requirements of this clause in the policy is not now involved.

(For other cases, see Insurance, Cent. Dig. §§ 617-620; Dec. Dig. § 282[8].)

Error from Superior Court, Chattooga County; Moses Wright, Judge. Action by M. J. Hughes against the Liverpool & London & Globe Insurance Company, Ltd. There was a judgment for plaintiff, and defendant brings error. Reversed.

King & Spalding and Daniel MacDougald, all of Atlanta, for Plaintiff in Error.

Wesley Shropshire, of Summerville, and Maddox & Doyal, of Rome, for Defendant in Error.



LEONARD ET AL. VS. FARMERS' MUT. FIRE INS. CO. OF MONROE AND WAYNE COUNTIES. (No. 228.)*

(Supreme Court of Michigan.)

1. INSURANCE—FIRE INSURANCE—ORAL APPLICATION—VALIDITY.

Where oral application for mutual fire insurance was made to agent who accepted payment of premium and fee, the question of the acceptance

* Decision rendered, July 21, 1916. 158 N. W. Rep. 1041.

of such application was for the jury, where the charter did not expressly forbid an oral application.

(For other cases, see Insurance, Cent. Dig. §§ 1734, 1755; Dec. Dig. § 668[3].)

2. INSURANCE—MUTUAL FIRE INSURANCE COMPANY'S CHARTER—CONSTRUCTION OF PROVISIONS.

The provisions of a mutual fire insurance company's charter under which it seeks to evade liability for loss will be strictly construed against the insurer.

(For other cases, see Insurance, Cent. Dig. § 312; Dec. Dig. § 152[1].)

3. INSURANCE—MUTUAL FIRE INSURANCE COMPANY'S CHARTER—EFFECT OF PROVISIONS.

The charter and by-laws of a mutual fire insurance company's charter are part of the contract of insurance, and compliance therewith cannot be waived by its officers.

(For other cases, see Insurance, Cent. Dig. §§ 948-951 956-965; Dec. Dig. § 375[1].)

4. INSURANCE—ASSIGNMENT OF POLICY—CONSENT OF INSURER.

Where the charter of the insurer required the written indorsement of consent of its president and secretary to all assignments, there could be no recovery on the theory that plaintiff was the assignee, where no written consent to an assignment was indorsed on the policy.

(For other cases, see Insurance, Cent. Dig. § 475; Dec. Dig. § 207[1].)

Error to Circuit Court, Monroe County; Guy M. Chester, Judge.

Action by Moses Leonard and another against the Farmers' Mutual Fire Insurance Company of Monroe and Wayne Counties. Judgment for plaintiff, and defendant brings error. Reversed, and new trial granted.

Argued before Stone, C. J., and Kuhn, Ostrander, Bird, Moore, Steere, Brooke, and Person, JJ.

Thornton Dixon, of Monroe, for Appellant.
Willis Baldwin, of Monroe, for Appellees.



HECKER vs. COMMERCIAL STATE BANK OF CARRINGTON.*

(Supreme Court of North Dakota.)

1. INSURANCE—FIRE INSURANCE—PLEDGE OF POLICY.

A policy of fire insurance may be pledged or assigned orally, as well as by means of a written instrument.

(For other cases, see Insurance, Cent. Dig. § 478; Dec. Dig. § 208.)

* Decision rendered, Aug. 1, 1916. On petition for rehearing, Sept. 8, 1916. 159 S. W. Rep. 97. Syllabus by the Court.

2. INSURANCE—FIRE INSURANCE—INSURABLE INTEREST.

A creditor, who loans to a business concern money and takes, as collateral security to such loan, an assignment or pledge of a fire insurance policy on the goods used by the borrower in the business for which the loan is made, has an insurable interest in said goods under the provisions of section 6466, Compiled Laws of 1913, which provides that "every interest in the property, or any relation thereto, or liability in respect thereof of such a nature that a contemplated peril might directly damage the insured is an insurable interest."

(For other cases, see Insurance, Cent. Dig. §§ 166, 167; Dec. Dig. § 121.)

Appeal from District Court, Foster County; Coffey, Judge.

Action by A. E. Hecker, as trustee in bankruptcy of Rose M. Geiger, bankrupt, against the Commercial State Bank of Carrington. From a judgment for defendant, plaintiff appeals. Affirmed.

Geo. H. Stillman, of Carrington, for Appellant.

T. F. McCue, of Carrington, for Respondent.

**WOLFF *vs.* GERMAN-AMERICAN FARMERS' MUT. INS. CO. (7423.)***

(Supreme Court of Oklahoma.)

1. INSURANCE—PLEADING—ESTOPPEL.

An estoppel or waiver of the conditions in a benefit certificate, in order to be available to the beneficiary in an action thereon, must be specifically and distinctly pleaded, and, if not so pleaded, evidence of such estoppel or waiver is not admissible at the trial.

(For other cases, see Insurance, Cent. Dig. §§ 1554, 1637, 1640; Dec. Dig. § 645[3].)

2. INSURANCE—ACTION—EVIDENCE OF WAIVER.

Where the by-laws of a mutual farmers' fire insurance company, made a part of the contract of insurance by the terms of the policy, provides, "In case of damage by fire or lightning a member is not entitled to compensation if he has not paid dues within thirty days after notification," and notice of dues on account of an assessment was given the member August 4, 1913, and the fire occurred November 24, 1913, and the dues were not paid until after the fire, and were paid into the bank, the company's depository, without notice of the fire, and the officers of the company, when notified of the payment, refused to accept the dues for the reason that a loss had occurred while the member was in default, and notified the member that the company would not accept the payment, and did not accept it, *held*, (a) That evidence of a waiver of this condition in the contract was incompetent because a waiver had not been pleaded; and (b) the evidence set out in the record, if competent, was insufficient to show a waiver of this condition; and (c) the order of the trial court sustaining a demurrer to the evidence was not error.

(For other cases, see Insurance, Cent. Dig. § 916; Dec. Dig. § 360[1].)

* Decision rendered, July 25, 1916. 159 Pac. Rep. 480. Syllabus by the Court.

Commissioner's Opinion, Division No. 2. Error from District Court, Noble County; W. M. Boles, Judge.

Action by George Wolff against the German-American Farmers' Mutual Insurance Company. From judgment for defendant, plaintiff appeals. Affirmed.

Cress & St. Clair, of Perry, for Plaintiff in Error.
H. A. Johnson, of Perry, for Defendant in Error.



**FASS ET AL. vs. LIVERPOOL, LONDON & GLOBE FIRE
INS. CO.—SAME vs. NORTH CAROLINA HOME
INS. CO.—SAME vs. INSURANCE CO. OF
NORTH AMERICA. (No. 9509.)***

(Supreme Court of South Carolina.)

1. INSURANCE—DENIAL OF LIABILITY—COMMENCEMENT OF ACTION—WAIVER.

In action on a policy of fire insurance, where insured gave due notice and proper proofs of loss, and an attempted adjustment failed, and that an attempted arbitration was had, and because of the partiality of the representative of the insurer and the umpire the plaintiff refused to accept the award, and the insurer refused to consider any further proposition and gave notice that it would settle only upon an acceptance of the award, the insurer's denial of a partial liability was a waiver of the provision against suit within sixty days of the award.

(For other cases, see Insurance, Cent. Dig. § 1551; Dec. Dig. § 623[4].)

2. INSURANCE—FIRE INSURANCE—ARBITRATION—PARTIALITY—INVALIDITY.

The partiality of the appraiser or arbitrator selected by an insurer invalidated the award, and was a defense against it and its acceptance.

(For other cases, see Insurance, Cent. Dig. §§ 1430-1432; Dec. Dig. § 574[3].)

Fraser, J., dissenting in part.

Appeal from Common Pleas Circuit Court of Dillon County; Thomas J. Mauldin, Judge.

Smith, Hammond & Smith, of Atlanta, Ga., and Sellers & Moore, of Dillon, for Appellants.

Gibson & Muller, of Dillon, for Respondents.

* Decision rendered, Sept. 14, 1916. 89 S. E. Rep. 1040.

**GLASSCOCK ET AL. vs. LIVERPOOL, LONDON & GLOBE
INS. CO. (No. 5594.)***

(Court of Civil Appeals of Texas. Austin.)

**1. INSURANCE—CANCELLATION—AUTHORITY OF AGENT—
QUESTION FOR JURY.**

In an action on a fire policy, where defendant claimed that the original policy had been canceled and a smaller policy substituted, held, on the evidence, that the authority of the insured's attorney to accept a notice of cancellation and substitution was for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1751, 1757; Dec. Dig. § 668[1].)

**2. INSURANCE—FIRE INSURANCE—CANCELLATION OF
POLICY—NECESSITY OF NOTICE TO MORTGAGEE.**

Under a policy of fire insurance on a warehouse, making loss payable to a mortgagee as her interest might appear subject to the terms of the policy, and providing that it might be canceled by the insurer by giving five days' notice of such cancellation, a cancellation by the insurer was not binding upon the mortgagee, to whom no notice of cancellation was given.

(For other cases, see Insurance, Cent. Dig. § 501; Dec. Dig. § 229[1].)

Appeal from District Court, Hays County; Frank S. Roberts, Judge. Action by W. D. Glasscock against the Liverpool & London & Globe Insurance Company, with petition of intervention by Fannie Manlove, seeking judgment against defendant. Judgment for plaintiff, motions by plaintiff and intervenor for new trial overruled, and they except and appeal. Reversed, and cause remanded for another trial.

R. E. McKie and E. M. Cape, both of San Marcos, for Appellant Glasscock.

Barber & Johnson, of San Marcos, for Appellant Manlove.

Thompson, Knight & Harris and Geo. S. Wright, all of Dallas, for Appellee.

* Decision rendered, May 17, 1916. Rehearing denied, June 28, 1916. 188 S. W. 281.



**MERCHANTS' & BANKERS' FIRE UNDERWRITERS vs.
BROOKS. (No. 5618.)***

(Court of Civil Appeals of Texas. Austin.)

1. INSURANCE—POLICY—IRON-SAFE CLAUSE.

Where policy, which did not, on its face, describe the goods insured, but contained a blank for such description to be pasted in the face of the policy, was inclosed in an envelope and sent to the insured, to-

* Decision rendered, April 19, 1916. On motion for rehearing, June 7, 1916. 188 S. W. Rep. 243.

gether with a paper containing an iron-safe clause and a description of the goods, the paper containing the iron-safe clause was not a part of the policy.

(For other cases, see Insurance, Cent. Dig. §§ 214, 215, 217; Dec. Dig. § 134[1].)

2. INSURANCE—IRON-SAFE CLAUSE—KNOWLEDGE OF INSURED.

The fact that insured did not know that there was to be an iron-safe clause in the policy would be immaterial, if it was in fact a part of the policy accepted by him.

(For other cases, see Insurance, Cent. Dig. §§ 222-224, 229, 230; Dec. Dig. § 136[5].)

3. INSURANCE—CONTRACT AND DESCRIPTION OF PROPERTY.

Where an application for a policy on furniture, etc., signed by insured, containing a full description of the goods insured, was attached to the policy and referred to in the face thereof, and made a part of it, the fact that the policy did not describe the goods insured, but contained a blank for such description to be pasted in, and that an iron-safe clause, which, together with a description of the goods, was contained in a paper sent with the policy to the insured, was not a part of the policy, did not prevent the making of a contract of insurance.

(For other cases, see Insurance, Cent. Dig. §§ 203, 211; Dec. Dig. § 133[1].)

4. INSURANCE—AMOUNT OF LOSS—STATUTE.

Under Acts 31st Leg. (4th Called Sess.) c. 8, § 18, relating to the business of fire insurance, the insured, under a policy known as an 80 per cent coinsurance clause, was a coinsurer entitled to recover that percentage of the policy, less the amount of his premium note and the amount allowed by the court for expense of adjustment, etc., with interest.

(For other cases, see Insurance, Cent. Dig. §§ 1270-1272; Dec. Dig. § 495[1].)

5. INSURANCE—PROOF OF LOSS—WAIVER—TIME.

The insurer's waiver of formal proof of loss was to be dated from the time of its examination of the insured.

(For other cases, see Insurance, Cent. Dig. §§ 1382, 1383, 1389, 1390; Dec. Dig. § 558[1].)

6. INSURANCE—FIRE INSURANCE—CHANGE IN OWNERSHIP.

Where an owner of furniture and a stock of goods had sold a half interest therein to his son, then eighteen years of age, taking his note therefor on which nothing was ever paid, and the facts as to such transaction were stated to the insurer's agent when he took the application for the policy, and where such owner always regarded himself as the owner, the policy was not void on account of a change in ownership.

(For other cases, see Insurance, Cent. Dig. § 795; Dec. Dig. § 328[2].)

7. INSURANCE—PAYMENT OF PREMIUM—PAID-UP INSURANCE.

While there can be no such thing as a paid-up fire insurance policy in the sense that under the terms of such policy either party may have the policy canceled, yet where the court deducted from the amount awarded to the insured the full amount of his premium note, including the amount due on a warehouse which was not destroyed, insured

would hold a policy for the amount insured on the warehouse during the time for which the premium had been paid.

(For other cases, see Insurance, Cent. Dig. §§ 396-398; Dec. Dig. § 186[1].)

8. INSURANCE—AMOUNT OF RECOVERY—EXPENSES OF ADJUSTMENT.

In an action on a fire insurance policy, covering furniture, groceries, and a stock of goods, agents of the insurer, who attempted to make an adjustment and who were being paid by the insurer a salary for their time without reference to such adjustment, were properly disallowed their claim of \$10 per day as expenses of adjustment.

(For other cases, see Insurance, Cent. Dig. §§ 1293, 1294; Dec. Dig. § 508.)

Error from District Court, Hamilton County.

Suit by W. C. Brooks against the Merchants' & Bankers' Fire Underwriters. Judgment for plaintiff, and defendant brings error. Reformed and affirmed.

Thompson, Knight, Baker & Harris and Will C. Thompson, all of Dallas, for Plaintiff in Error.

Dewey Langford and H. E. Chesley, both of Hamilton, for Defendant in Error.



WESTCHESTER FIRE INS. CO. vs. McMINN. (No. 1656.)*

(Court of Civil Appeals of Texas. Texarkana.)

1. INSURANCE—FIRE INSURANCE—BREACH OF POLICY—STATUTE.

The breach of a provision of a fire insurance policy, requiring the insured to take an annual inventory and to keep a complete record of his business, bars a recovery; the provisions of Vernon's Sayles's Ann. Civ. St. 1914, art. 4874a, providing that recovery shall not be defeated by breach of provisions which did not contribute to the loss or destruction of the insured property, not being applicable to breach of such provisions.

(For other cases, see Insurance, Cent. Dig. § 853; Dec. Dig. § 335[1].)

3. INSURANCE—ACTION—CANCELLATION OF FIRE INSURANCE POLICY—SUBMISSION TO JURY—SUFFICIENCY OF EVIDENCE.

Evidence held sufficient to require the submission to the jury of the issue whether there was a mutual cancellation of a fire insurance policy before the fire.

(For other cases, see Insurance, Cent. Dig. § 1556; Dec. Dig. § 668[1].)

4. INSURANCE—FIRE INSURANCE—CANCELLATION OF POLICY—MUTUAL AGREEMENT—PAYMENT OF UN-EARNED PREMIUM.

A policy of fire insurance may be canceled at any time before loss by agreement between the parties, independent of the terms of the policy;

* Decision rendered, June 15, 1916. 188 S. W. Rep. 25.

and in such case the immediate payment of the unearned premium may not be required in order to make valid the agreed cancellation.
(For other cases, see Insurance, Cent. Dig. §§ 498, 499, 509-512; Dec. Dig. § 226, 230.)

Error from District Court, Franklin County; H. F. O'Neal, Judge.
Action by M. W. McMinn against the Westchester Fire Insurance Company. Judgment for plaintiff, and defendant brings error. Reversed and remanded for new trial.

Thompson, Knight, Baker & Harris, of Dallas, for Plaintiff in Error.
R. T. Wilkinson, of Mt. Vernon, for Defendant in Error.

FIRE ASS'N OF PHILADELPHIA *vs.* POWELL ET AL.
(No. 1647.)*

(Court of Civil Appeals of Texas. Texarkana.)

1. INSURANCE—ACTIONS—SUFFICIENCY OF EVIDENCE—DELIVERY OF POLICY.

Evidence held to sustain a verdict that a fire insurance policy was intended to become effective without waiting for its approval by the insurance company's general agents.

(For other cases, see Insurance, Cent. Dig. § 1709; Dec. Dig. § 665[2].)

3. INSURANCE—CONTRACT—CONSTRUCTION—DESCRIPTION OF PROPERTY—"FURNITURE" AND "FIXTURES."

"Furniture" and "fixtures," as used in a fire insurance policy, include light fixtures and globes, ceiling fans, electric meters, mirror door, and the wiring of a building.

(For other cases, see Insurance, Cent. Dig. § 343; Dec. Dig. § 163[4].)

(For other definitions, see Words and Phrases, First and Second Series, Fixtures; Furniture.)

4. INSURANCE—ACTIONS—ADMISSIBILITY OF EVIDENCE—DELIVERY OF POLICY.

Under an issue whether a fire insurance policy was intended to become effective before approval by the insurer's general agents, the undisclosed intention of the insurer's general agent when making the contract is inadmissible.

(For other cases, see Insurance, Cent. Dig. § 1674; Dec. Dig. § 651[2].)

Appeal from District Court, Hill County; Horton B. Porter, Judge.
Action by L. H. Powell and another against the Fire Association of Philadelphia, in which Ray Carroll intervened. From an adverse judgment, defendant appeals. Affirmed.

Crane & Crane, of Dallas, and Morrow & Morrow, of Hillsboro, for Appellant.

Leake & Henry, of Dallas, and Edwards, Geppert & Wroe, of Teague, for Appellees.

* Decision rendered, May 11, 1916. Rehearing denied, June 1, 1916. 188
S. W. Rep. 47.

VIOLETTE *vs.* INSURANCE CO. OF THE STATE OF
PENNSYLVANIA. (No. 13275.)*

(Supreme Court of Washington.)

1. INSURANCE—ACTIONS—BURDEN OF PROOF—POWERS OF AGENT.

Where the insurer denies the power of one assuming to write a policy as agent, the party so dealing with him must prove either that such person was the actual agent, or that the insurer is estopped to deny the agency.

(For other cases, see Insurance, Cent. Dig. § 101; Dec. Dig. § 76.)

2. INSURANCE—POWERS OF AGENT—ESTOPPEL TO DENY AGENCY—“OSTENSIBLE AGENCY.”

The insurer having appointed M. F. H., a woman, its agent, and its manager dealt with C. E. H., her husband, who conducted the business of the agency and wrote policies in the name of M. F. H. and held himself out as the agent, and was supposed by the insurer to be M. F. H., he became the ostensible agent, and as against one dealing with him as such, the insurer was estopped to deny his authority.

(For other cases, see Insurance, Cent. Dig. § 102; Dec. Dig. § 77.)

(For other definitions, see Words and Phrases, First and Second Series, *Ostensible Agency*.)

3. INSURANCE—REGULATION—ISSUANCE OF POLICIES.

3 Rem. & Bal. Code, § 6059-36, making it unlawful for an insurance company to write a policy unless countersigned by its duly authorized agent, does not make a policy void, if signed by one assuming to act as agent, though he was not its licensed agent.

(For other cases, see Insurance, Cent. Dig. §§ 246-249; Dec. Dig. § 138[1].)

4. INSURANCE—CANCELLATION OF POLICY—WAIVER OF NOTICE.

Provision of policy requiring five days' written notice of cancellation may be waived by the insured.

(For other cases, see Insurance, Cent. Dig. § 501; Dec. Dig. § 229[1].)

5. INSURANCE—CANCELLATION OF POLICY—WAIVER OF NOTICE.

Where insurer ordered cancellation of policy containing requirement of five days' written notice of cancellation, and, when the agent verbally notified the insured, he requested that the risk be written in another company, the first policy was canceled when the new policy issued, though no other notice was given.

(For other cases, see Insurance, Cent. Dig. §§ 500-502; Dec. Dig. § 229[2].)

Department 2. Appeal from Superior Court, Chelan County; Wm. A. Grimshaw, Judge.

Action by J. B. Violette against the Insurance Company of the State of Pennsylvania. From a judgment of nonsuit, plaintiff appeals. Reversed, and judgment ordered for plaintiff.

C. B. Hughes and Hughes & Adams, all of Wenatchee, for Appellant.
Granger & Clarke, of Seattle, for Respondent.

* Decision rendered, Aug. 30, 1916. 159 Pac. Rep. 896.

MARINE.

**UNITED STATES CIRCUIT COURT OF APPEALS.
NINTH CIRCUIT.**

FIREMAN'S FUND INS. CO.

vs.

GLOBE NAV. CO. ET AL. (No. 2630.)*

**INSURANCE—MARINE INSURANCE—LIABILITY OF INSURER—
INSURANCE OF FREIGHT ADVANCED BY SHIPPER.**

Pursuant to the terms of the charter party, a charterer made an advance on freight, deducting the cost of insurance, and taking the receipt on draft of the master. Thereupon it insured the freight in its own name to the amount of the advance. The ship became disabled in a storm, the voyage was abandoned, and the insurer paid the insurance to the charterer, taking an assignment of the master's receipt. *Heid*, that it could not recover thereon against the shipowner, for whose ultimate benefit the insurance was effected, through the charterer as its agent.

(For other cases, see Insurance, Cent. Dig. §§ 1512, 1513; Dec. Dig. § 607.)

Appeal from the District Court of the United States for the Northern Division of the Western District of Washington; Jeremiah Neterer, Judge. Suit in personam in admiralty by the Fireman's Fund Insurance Company against the Globe Navigation Company and S. P. Weston, its trustee in bankruptcy, on an instrument in writing executed by A. W. Swenson, master of the American schooner Wm. Nottingham, as agent for said Navigation Company. Decree for respondents, and libelant appeals. Affirmed.

Before Gilbert and Morrow, Circuit Judges, and Rudkin, District Judge.

Edward J. McCutchen, Ira A. Campbell, and McCutchen, Olney & Willard, all of San Francisco, Cal., and Ballinger, Battle, Hulbert & Shorts, of Seattle, Wash., for Appellant.
Clise & Poe, of Seattle, Wash., for Appellees.

MORROW, C. J.

On June 3, 1911, W. R. Grace & Co. chartered the American schooner Wm. Nottingham owned by the respondent, Globe Navigation Company. Under the terms of the charter party it was provided that:—

“A sufficient amount for ship's ordinary disbursements at port of loading, say not exceeding one-third of the freight, to be advanced by charterers, if required by captain, on account of freight

* Decision rendered, May 15, 1916. 234 Fed. Rep. 273.

under this charter party, subject to a charge of 7 per cent to cover interest, insurance and commission; advance to be indorsed on captain's copy of charter party and all the bills of lading."

No advance was indorsed on captain's copy of the charter party, nor was any such indorsement made on any of the bills of lading; but the charterer, before the vessel set sail, advanced to the captain the sum of £1,560, British sterling (\$8,032.20). Upon receipt of that sum, the captain gave W. R. Grace & Co. an instrument in writing, in words and figures as follows:—

"£1,650/o/o Stg.

Seattle, Sept. 27, 1911.

"At sight after arrival of the American schooner Wm. Nottingham, under my command, at the port of Callao, or any other place at which her voyage may terminate, I promise to pay to the order of W. R. Grace & Co. the sum of sixteen hundred fifty pounds (£1,650/o/o) British sterling, or approved bankers' demand bills on London, for freight advance received at Seattle, Wash., as per receipt given, for the payment of which I hereby pledge my vessel and her freight; and I hereby assign to the legal holder of the obligation all my lien and claim against freight, vessel, and owners, with power to take in my name any and all steps necessary to enforce the same; and my consignees at port of discharge are hereby instructed to pay this obligation, and deduct the amount thereof from the freight due said vessel. In case of nonpayment, the holder shall also be entitled to the benefit of all liens in law, equity, or admiralty which the master or owners of the vessel may be entitled to against any part of the cargo or its owners for freight, or any other charges whatsoever. This claim to have priority of payment over all others that may be presented against the said freight and vessel. My vessel is now lying at the port of Astoria, Ore., loaded with cargo Oregon pine and ready to sail for Callao, Peru.

"Signed in triplicate; one being accomplished, the others to stand void."

"A. W. Swenson,
"Master Am. Schr. Wm. Nottingham."

On October 6, 1911, W. R. Grace & Co. took out insurance on the advance mentioned in the foregoing writing, with Fireman's Fund Insuranec Company, the libelant herein; premium for such insurance being paid by W. R. Grace & Co. for the respondent, the former deducting that amount from the sum advanced under the terms of the charter party. On October 2, 1911, the schooner sailed from the port of Westport, Ore., for Callao, Peru, with a full cargo of lumber for delivery at the latter port. She never reached her destination. Shortly after sailing she became water logged and was dismasted off the Columbia river. The vessel was abandoned at sea by her master, officers and crew, was subsequently picked up by a tug and towed to the port of Astoria,

and was later towed to the port of St. Johns, Ore., where her cargo that had not been washed overboard was discharged and delivered to W. R. Grace & Co., the owner of the cargo, and the voyage terminated. Claim was thereupon made to the libelant by W. R. Grace & Co. for the insurance, amounting to \$7,920, which was paid by the libelant; and in consideration of the payment of the insurance W. R. Grace & Co. assigned to libelant all its right, title, and interest in and to the "interest, whether on account of salvage therefrom or on any other account whatever." This libel was thereafter filed by the insurance company against the respondent, based upon the instrument signed by the master of the schooner, dated September 27, 1911.

The libelant alleged, among other things, that on February 14, 1912, for a valuable consideration, W. R. Grace & Co. assigned unto the libelant all of its right, title, and interest in and to its claim for the repayment of the said £1,650; that the libelant was the owner and holder of the claim and of the lien; that demand for payment of the indebtedness had been made by libelant upon respondent, and payment thereof had been refused; and that the amount (\$8,032.20) remained unpaid and was due the libelant by respondent. It was further alleged that during the time mentioned the schooner Wm. Nottingham was owned by the respondent, and Swenson was the agent of the respondent in the execution of the instrument and in the receipt of the advance freight mentioned.

The answer of respondent admits that during all the times mentioned in the libel it was the owner of the schooner Wm. Nottingham, and that Swenson was the master thereof, but denies, among other things, that at any time Swenson was the agent of respondent in the execution of the instrument described in the libel, denies that he ever received the advance against freight mentioned in the libel, denies that W. R. Grace & Co. became the owner and holder of the instrument for a valuable consideration, or at all, denies that respondent has any knowledge that on February 14, 1912, or at any other time, for a valuable consideration, or at all, W. R. Grace & Co. assigned to the libelant all of its right, title, and interest in and to the said instrument described in the libel, and denies that it has knowledge as to whether said libelant is the owner and holder of said claim, and asks strict proof of same. The insurer alleges, further, that:

"For a consideration therein [charter party] agreed upon, and as a part of the consideration therefor, it was agreed that one-third of the freight would be advanced and paid by charterers on account of the freight under said charter party, subject to a charge of 7 per cent to cover interest, insurance, and commission; that when said schooner was fully laden and ready for sea said W. R. Grace & Co. advanced to this respondent the sum of £1,650 British sterling, and said W. R. Grace & Co. thereupon under the terms of said charter party insured the same, and

charged the cost or premium therefor to this respondent, and respondent paid the same by allowing said W. R. Grace & Co. to deduct the same from one-third of the freight due under said charter party, said sum of £1,650 British sterling being said one-third of freight, less deduction of 7 per cent as provided in said policy [charter party] for insurance charges and interest."

The libelant is an insurance company, and it appears in evidence that on October 6, 1911, it issued a certificate of insurance to W. R. Grace & Co. in the sum of \$7,920 on advances valued at sum insured. On the margin of the certificate of insurance is indorsed the following:—

"This insurance is to cover against all the perils enumerated in the policy which may prevent the collection of said draft in whole or in part, including general average, salvage, and/or other charges arising from sea peril to which the advances hereby insured may be subjected. The ownership of draft to be deemed sufficient proof of interest."

It appears that the libelant did not write the insurance based upon the master's receipt or draft of September 27, 1911, and did not know of its existence until the loss had occurred. After the loss had occurred and the insurance had been paid, libelant took an assignment of the receipt or draft for the purpose of securing a return of the insurance; but the insurance had been paid in accordance with the terms of the policy, written by itself upon the receipt of a premium paid by the respondent through Grace & Co., acting for the respondent in the transaction. Had the voyage of the schooner been completed and the cargo delivered to the consignees, the amount of the receipt or draft would have been deducted by them from the freight due the vessel as advance or prepaid freight, and the respondent would have sustained no loss. The failure of the schooner to make the voyage and deliver the cargo resulted in a loss to the respondent of the freight on the cargo, including the advance or prepaid freight. The loss arose from a sea peril, to which the advance or prepaid freight insured in the policy was subjected. To protect the respondent against this loss, the libelant, upon the payment of the regular premium, issued its policy of insurance payable to Grace & Co., or order. It was paid by the libelant on the order of Grace & Co. upon the risk and for the loss for which the libelant had insured its policy.

E. T. Ford, the submanager of Grace & Co. at Seattle, in the state of Washington, testified that in placing the insurance with the libelant:—

"We were acting for the Globe Navigation Company, to whom we charged and collected the amount of the premium. * * * We chartered this vessel and agreed to pay a certain amount of freight for her. At the same time we agreed to make a certain amount of advance against the freight, which we did. The advance we insured, and, in so doing, we practically stepped into the

position of the Globe Navigation Company in insuring our own freight, with the understanding that, if they insured the freight, they would not insure more than the balance over the amount of this advance."

The question, in this case, is not whether the shipper, upon the loss of his cargo, can recover advanced freight from the owner of the vessel, either as advanced freight or upon the receipt or draft of the master; but the question is: Can the insurance company avoid its liability to the insured because the insurance was effected through the shipper as agent for the shipowner? We think not. It seems to us to require no discussion of cases to show that, upon the contract of insurance, the loss should remain with the libelant.

This conclusion renders it unnecessary to discuss the question of whether libelant mistook its remedy in suing upon the master's receipt or draft, instead of advance or prepaid freight. We do not think the libelant is entitled to recover upon either aspect of the case.

The decree of the District Court is affirmed.

ACCIDENT AND HEALTH.**SUPREME COURT OF GEORGIA.****ROGERS****v.s.****AMERICAN NAT. INS. CO.****AMERICAN NAT. INS. CO.****v.s.****ROGERS. (No. 566.)*****1. INSURANCE—EXECUTION OF CONTRACT—SIGNATURE BY LOCAL AGENT—WAIVER—PLEADING.**

A clause in an insurance policy, providing that the contract of insurance "shall not be valid until countersigned by" the agent of the company at the place where the insured resides, may be waived; and, if the policy of insurance be otherwise duly executed and valid, it will be binding upon the company.

- (a) Allegations, to the effect that the company delivered the policy and received the policy fee and premium provided by the policy to be paid, and that the company had treated the insured as a policyholder in mailing a postal card, informing him as to the rules of the company with respect to payment of monthly premiums, were sufficient to authorize the conclusion that the company waived the necessity of the signature of the local agent.

(For other cases, see *Insurance*, Cent. Dig. § 254; Dec. Dig. § 141[1].)

2. INSURANCE—ACTIONS ON POLICIES—PLEADING.

The policy provided that the premiums should be paid on the first of each month. It was alleged that certain premiums had been paid, and that the company had notified the insured that the premiums would be accepted if made by the eighth of the month. The insured was injured on the sixth of the month, and died on the eighth. On the seventh, the insured sent to the company the premium with the card containing the notice, and when delivered at the office those in charge tore up the card and refused to receive the premium. Properly construed, the allegations in regard to the premiums that had been paid had reference to premiums due prior to the first of the month, and the allegations with respect to notice by the company of extension of time for payment of premiums and tender of premiums within the time were sufficient to charge that the insured was not in arrears on the matter of payment of premiums.

(For other cases, see *Insurance*, Cent. Dig. § 1575; Dec. Dig. § 629[1].)

* Decision rendered, Aug. 15, 1916. 89 S. E. Rep. 700. Syllabus by the Court.

3. INSURANCE—ACTIONS ON POLICIES—PLEADING.

The allegations relating to claim for attorney's fees and damages as provided in the statute were sufficient to withstand a general demurrer.

(For other cases, see Insurance, Cent. Dig. §§ 1599-1602; Dec. Dig. § 635.)

4. INSURANCE—ACTIONS ON POLICIES—SUFFICIENCY OF EVIDENCE.

The evidence failed to support the allegations as to extension of the time of payment of monthly premiums, but showed affirmatively that the premiums were past due at the time the insured was injured, which, under the terms of the contract, rendered the policy ineffective. Accordingly, a judgment of nonsuit was proper.

(For other cases, see Insurance, Cent. Dig. §§ 1711-1716; Dec. Dig. § 665[3].)

Error from Superior Court, Chatham County; W. G. Charlton, Judge.

Action by Elizabeth Rogers against the American National Insurance Company. Judgment for defendant, and plaintiff brings error, and defendant files a cross-bill of exceptions. Affirmed.

Elizabeth Rogers, as beneficiary under an accident insurance policy, instituted an action against the American National Insurance Company of Galveston, Tex. The defendant filed a demurrer to the petition, upon general and special grounds, some of which grounds were sustained and others overruled. The plaintiff amended to meet those grounds of demurrer which were sustained; and the defendant renewed its demurrer to the petition as amended, which demurrer was overruled. The case proceeded to trial, and at the conclusion of the evidence a judgment of nonsuit was granted. The plaintiff filed a bill of exceptions, in which the only assignment of error was upon the judgment of nonsuit. Thereafter in due course the defendant, having excepted pendente lite to the adverse rulings on demurrer, sued out a cross-bill of exceptions, assigning error upon the exceptions pendente lite, and upon certain rulings on the admissibility of evidence. The other material facts appear in the opinion.

W. R. Hewlett and H. P. Cobb, both of Savannah, for Plaintiff in Error.

Osborne, Lawrence & Abrahams, of Savannah, for Defendant in Error.

ATKINSON, J.

[1] This was an action against an insurance company, instituted by a beneficiary named in the policy of insurance, to recover an indemnity on account of the death of the insured, her husband, caused by accidental means against which the policy purported to insure. The petition set forth a copy of the policy of insurance, and alleged in general terms that the policy had been duly issued and assented to by the company and delivered by it to the insured, and that all the payments required thereunder had been duly made and the policy accepted by the insured. The policy was dated February 13, 1913, and the insured suffered an accident under circumstances as contemplated by the policy on March 6, 1913, producing the injury from which he died on March 8th. The plaintiff furnished proofs of death within the time provided by the policy, and the company refused to con-

sider them or pay any amount under the policy. The insurance clause of the policy recited that the company—
“in consideration of the policy fee, the premiums, and of the statements, agreements, conditions, and warranties in the schedule indorsed or printed hereon and made a part hereof, which statements the insured makes on acceptance of this policy and warrants to be true, does hereby insure [naming the plaintiff's husband] subject to all of the conditions herein contained and indorsed hereon, from 12:00 noon, central standard time, of the day this contract is dated [February 13, 1913] until 12:00 noon, central standard time, of the first day of March, 1913, and for such further periods stated in the renewal receipts as the payment of the premium specified in the schedule will maintain this policy and insurance in force, against death or disability resulting directly, and exclusively of all other causes, from bodily injury sustained solely through external, violent, and accidental means, said bodily injury being hereinafter referred to as ‘such injury,’ and against death and disability from any bodily disease or illness as follows,” etc.

In the schedule it is provided that:—

“The insurance is not effective until the policy has actually been issued by the company and the premium paid, and that the company is not bound by any knowledge of or statement made by or to any agent, unless written hereon. I further agree to accept the policy subject to all its conditions and pay the monthly premium of one and $\frac{99}{100}$ dollars in advance without notice.”

Following this statement was the signature of the insured, and immediately following was the clause:—

“In witness whereof the said company has caused this policy to be signed by its president and the secretary; but the same shall not be valid until countersigned by F. A. Walter, agent of the company at Savannah, Ga.”

Then follow the signatures of L. H. Collier, secretary, and W. L. Moody, Jr., president. After these signatures were the words, “Countersigned at Savannah, Ga., on this 13th day of February, 1913,” but there was no signature to this statement.

It was urged by the demurrer that the petition did not allege a cause of action, because it appeared that there had not been a valid execution and delivery of the policy of insurance. The basis of this contention was that the paper contained the provision that “the same shall not be valid until countersigned by F. A. Walter, agent of the company at Savannah, Georgia,” and, while signed by the president and secretary, it appeared from the face of the pleadings that it was not signed by the local agent at Savannah. In *Kantrener vs. Pa. Mutual Life Ins. Co.*, 5 Mo. App. 581, it was said by Blakewell, J.:—

“The countersigning of a policy by the insurer's agent, though expressly required by the terms of the policy, is not absolutely essential; and, where the intention to execute the contract is

sufficiently apparent, it may be considered as waived and dispensed with."

The case of *Prall vs. Mutual Protective Life Ins. Society*, 5 Daly (N. Y.) 298, was an action upon a life insurance policy. The defense, among other things, was that the policy had never been delivered, and that the consideration for the issuance of the policy had never been paid. On the trial the plaintiff produced in court the policy on Shader's life, duly executed by the defendant, which recited that it was made in consideration of \$12.56, "duly paid by Wesley E. Shader." It was also recited in the body of the policy that it was issued and accepted "upon the express condition and agreements contained on the back hereof." One of these conditions was that the policy, although delivered, should not take effect or be put in force until the first premium was actually paid, and that no official or agent of the society had power or authority to deliver the policy until such actual payment, nor to waive the actual payment of the premium on the delivery of the policy. It was also recited in the body of the policy that it was to take effect "only when countersigned by D. G. Bloss, general agent at ____." The policy was not countersigned by D. G. Bloss, and on that ground the defendant objected to its being received in evidence. The objections were sustained, and the plaintiff excepted. In the opinion, it was said by Daly, C. J.:-

"The possession of the policy by the assured affords, in the absence of anything to the contrary, a presumption that it was delivered as evidence of a concluded contract. But the plaintiff was met by the difficulty in this case that the last clause in the instrument produced by him declared that 'the policy was to take effect only when countersigned by D. G. Bloss, general agent at _____,' the place being left blank, and there can be no presumption of a concluded contract from the possession, where the instrument has not been countersigned in the manner provided for. This condition may, of course, be waived; and, if it had been shown that the premium had been received and the policy delivered by the company, without having this indorsement put upon it, it would be regarded as waived."

In *Myers vs. Keystone Mutual Life Insurance Co.*, 27 Pa., 268, 67 Am. Dec. 462, it was held:-

"Although a policy may expressly require the countersigning by an agent of the company, it may be dispensed with where the intention to execute is sufficiently plain."

In *Badger vs. American Popular Life Insurance Co.*, 103 Mass. 244, 4 Am. Rep. 547, it was held:-

"A policy of life insurance which provides that it shall not be in force until countersigned by 'A. B., agent,' is invalid till so countersigned, although A. B. is himself the assured and the policy has been received and retained by him."

The opinion was, in substance, as indicated by the note quoted above, but concluded with the language:—

"There is no evidence tending to show that it was waived."

The clause in the policy under consideration was for the benefit of the insurer, which it could waive without injury to the insured or the beneficiary. When the clause is considered in connection with the allegations to the effect that the company delivered the policy and received the policy fee and premium required by the terms of the policy to be paid, and that the company had treated the insured as a policyholder in mailing a postal card informing him as to the rules of the company with respect to the payment of monthly premiums, an intention to waive the necessity of the signature by the local agent is manifested. See, also, 1 Cooley's Briefs on Insurance, 441; Kerr on Ins. 85, § 40; Terry vs. Provident Fund Society, 13 Ind. App. 1, 41 N. E. 18, 55 Am. St. Rep. 217; Jurgens vs. New York Life Ins. Co., 114 Cal. 161, 45 Pac. 1054, 46 Pac. 386.

[2] 2. Another ground of general demurrer was that it appeared from the pleading that, on account of nonpayment of premiums when due, the policy was not in effect at the time of the injury to the insured. The policy fee was a sum separate and apart from the premium. It was alleged that the insured paid—

"an amount termed the policy fee * * * some days prior to February 13, 1913, to one R. L. Clanton, the soliciting agent for the insurance company; the exact amount or date upon which said payment was made petitioner is unable to state."

Also, that the insured paid "a certain sum of money on February 24th, covering a monthly premium of the policy." The policy provided that all such premiums should be paid on the 1st of the month, and, properly construed, the above allegations refer to payment of the policy fee and the premium for the month of February. There was no allegation of the payment of any premium for the month of March; but, as an excuse therefor, it was alleged that the insured received a notice from the company that such a payment would be accepted if made by the 8th of the month, and that, acting upon the faith of such notice, the plaintiff, on March 7th, sent an agent with the card and money with which to pay the premium to the office of the defendant, when those in charge of the office refused to receive the money, but took the card and destroyed it. We think this is a sufficient allegation that before the injury the company extended the time for payment of the premium under the policy for the month of March, and notwithstanding the extension of time, refused to accept the payment of the premium when tendered according to the rules which it had promulgated; and the petition was not subject to general demurrer on the ground taken.

[3] 3. In addition to suing for the amount agreed to be paid upon the death claim according to the terms of the policy, the

petition also alleged that the company, in refusing to pay in accordance with the terms of the policy, had acted in bad faith, and by reason thereof petitioner had been compelled to employ counsel to enforce her rights in the premises, and thereupon she claimed 25 per cent damages and \$50 attorney's fees on account of the bad faith of the company in refusing to pay the sum. A demurrer was interposed to this part of the petition, on the ground that the allegation as to bad faith were mere matters of opinion, and no facts were alleged upon which to base the allegation. It is declared in Civil Code, § 2549:—

"The several insurance companies of this state, and foreign insurance companies doing business in this state, in all cases when a loss occurs, and they refuse to pay the same within sixty days after a demand shall have been made by the holder of the policy on which said loss occurred, shall be liable to pay the holder of said policy, in addition to the loss, not more than 25 per cent on the liability of said company for said loss; also, all reasonable attorney's fees for the prosecution of the case against said company. Provided, it shall be made to appear to the jury trying the same that the refusal of the company to pay said loss was in bad faith."

The effort to recover damages and attorney's fees was based on the foregoing statute. According to the allegations of the petition, the insured was injured on March 6, and died on March 8, 1913. The action was commenced October 28, 1913, more than sixty days after the alleged filing of proof of death. When considered in connection with other allegations of the petition, as indicated above, the allegations with respect to claim for attorney's fees did not amount to mere expression of opinion, but were a sufficient compliance with the statute to authorize the plaintiff to go before the jury and ask for damages and attorney's fees as provided for in the statute.

[4] 4 On the trial the plaintiff failed to prove her case. When examined as a witness, she testified to a payment of \$2, made on the 24th of February, to the soliciting agent, Clanton, at the time the policy was delivered, that at the time of the payment the agent stated "that payment made \$4, and gave receipt for it," and that she never saw any other money paid to the company. She also testified:—

"When he got hurt he had received a postal card, and under that he had to pay some money at the insurance company's office. I knew it had been due since the first of the month, and my husband was trying to raise it, but had not been able to do so up to the 6th of March. * * * He got hurt on the 6th. That was the time we finally got the money up. * * * Mr. Smith gave the money, and before he could get back home to me to send the money he got hurt. * * * He got hurt between 3 and 4 o'clock. After he got hurt I sent the girl with the money. I went

to the office after he died; that was the only time that I went to the office."

The receipt referred to by the witness was introduced in evidence, and was as follows:—

"American National Insurance Company. (Incorporated by the State of Texas. Home office, Galveston, Texas). No. [in lead pencil] 2. February 24th, 1913. Received from James Alton Rogers _____ [in small type] cents, which is a deposit on account of application this day made for insurance in the above-named company. No obligation is incurred by said company by reason of this deposit, unless said application is accepted, and until a policy is delivered by an agent of the company in person to the applicant. If this application of insurance be rejected, or policy not delivered, this deposit will be returned to applicant.

"R. L. Clanton, Agent."

Another witness for the plaintiff testified that in 1913 he had been employed by the defendant company in the local office at Savannah, and had seen printed cards containing notices to be sent out to policyholders; that these cards had printed thereon words something like these: "Must be paid on or before the 8th of March, or the policy will be void;" and that these cards were signed by the local agent. A blank card was produced by the defendant, under notice, as follows:—

"American National Insurance Company.
"Monthly Premium Department.

"Galveston, Texas.

"\$200,000 deposited with the state treasurer of Texas for the protection of policyholders.

"Your _____ on policy No. _____ will be due and must be paid to American National Insurance Company, Accident Department, Galveston, Texas, or to _____ on or before _____ 1st, 191—, or your policy of insurance will be void. Always take this notice to local collector, so he can find your name without delay. Policyholder making payments to other than the person named in this notice or at the home office do so at their own risk. The printing and mailing of this notice to a policyholder in arrears shall not be held to waive forfeiture or lapse of policy which may have occurred from any cause."

Another witness testified that she went to the company's office on the 8th and carried with her \$1.95, and that the agent of the company refused to receive the money, but took the notification card and tore it up. There was other evidence that the insured died on March 8th, from the accident received and that the plaintiff notified the company of his death.

Considering all the evidence, it clearly appears that the only premium payment made and referred to in the receipt given by the company's agent was that due for February, and that the plaintiff and the insured knew that the premium for March was

due on the 1st. There was no evidence that the company authorized the local agent to extend the time for payment. The policy contained the provision that premiums are due the 1st of each month in advance; and the further provision that:—

"If the payment of any renewal premium shall be made at [after?] the expiration of this policy or the last renewal receipt, neither the insured nor the beneficiary will be entitled to recover for any accidental injury happening between the dates of such expiration and 12:00 o'clock noon, central standard time, of the day following the date of such renewal payment."

Inasmuch as the March premium was due on the 1st and had not been paid at the time of the injury, the policy was in arrears, and the insurance theretofore existing was not operative. The effort on the part of the plaintiff to pay the overdue premium after the injury had been received was not in compliance with the terms of the contract, and the agent properly rejected the money when tendered.

Judgment affirmed on both bills of exceptions. All the Justices concur.

SUPREME COURT OF IOWA.

RILEY

vs.

INTERSTATE BUSINESS MEN'S ACC. ASS'N. (No. 30028.)*

1. INSURANCE—CONDITIONS PRECEDENT—PLEADING.

Under Code 1897, § 3626, providing that in pleading the performance of conditions precedent in a contract the party may state generally that he duly performed all the conditions on his part, the plaintiff, in an action on a benefit certificate, was not required to plead more than that her decedent had a described certificate, that he met his death in a manner covered thereby, and that all the conditions thereof had been complied with leaving the defendant's answer to set out its articles of incorporation.

(For other cases, see Insurance, Cent. Dig. § 1996; Dec. Dig. § 815[1].)

3. INSURANCE—ACCIDENT INSURANCE—CONSTRUCTION.

The words of a certificate of accident insurance, singling out the voluntary or involuntary taking of poison as an exception, were intended to be effective and to state the exception to the uttermost extent intended, and not to include death by poison in any other manner.

(For other cases, see Insurance, Cent. Dig. §§ 1955, 1957-1959; Dec. Dig. § 787.)

* Decision rendered, Sept. 23, 1916. 159 N. W. Rep. 203.

Appeal from District Court, Linn County; Milo P. Smith, Judge.

Demurrer to plaintiff's petition sustained. She appeals. On rehearing, reversing 152 N. W., 617.

Tourtellot & Donnelly, of Cedar Rapids, and Edwards, Longley & Ransier, of Waterloo, for Appellant.

Dunshee & Haines, of Des Moines, for Appellee.

SALINGER, J.

[1, 2] I. Section 3626 of the Code of 1897 provides that in pleading the performance of conditions precedent in a contract, it is not necessary to state the facts constituting such performance, but the party may state generally that he duly performed all the conditions on his part. It seems to be contemplated that under this statute the answer of the defendant is to set out its articles of incorporation. Krause vs. Modern Woodmen, 133 Iowa, at page 203, 110 N. W. 452. In Clark vs. Riddle, 101 Iowa, 270, 70 N. W. 207, there is involved an injunction to restrain illegal sale of intoxicating liquors. It is conceded, of course, that the sale of liquor of itself proves an illegal sale, and that, therefore, it is upon the defendant to set up the bar of what is known as the mulct law. It is said that a general allegation that whatsoever business was carried on under and by virtue of the provisions and privileges of that law (citing the statute), is probably sufficient because said section of the statute authorizes the performance of conditions precedent to be stated generally. In Brock vs. Des Moines Insurance Co., 96 Iowa 39, 64 N. W. 685, this statute was applied to pleading that proof of loss required had been made. In the same case it is held that the statute can be waived, and that where the facts constituting proof of loss are stated, a general denial puts the making of the proof in issue, and there will be a failure of proof if the facts stated do not constitute sufficient proof of loss. It would seem, therefore, that plaintiff was under no requirement to plead more than that her decedent had a described certificate, generally, that he had met his death in a manner covered by the certificate, and that all conditions thereof had been complied with. But plaintiff chose to do more. While, therefore, the statute does not aid her, and she must take the consequences of her volunteer pleading, that consequence is on demurrer no more than that the volunteer matter is an admission. If what is thus admitted avoids a recovery, demurrer will defeat her. It follows that the demurrer is not good merely because the case stated is not enough to recover on, but can be effective only if that be affirmatively admitted which defeats the action. The sole question we have on this record is whether there are such affirmative admissions.

[3-5] (2) A copy of the application is attached to the petition as Exhibit A, and made part thereof, and a copy of the certificate of membership issued on the application, and a synopsis of the articles of incorporation and by-laws, are attached as Exhibit C.

One provision of Exhibit C is that the defendant will pay for a death which results within six months after injury, and which results "from bodily injuries effected solely by external, violent, and accidental means, and without intervening cause." Another provision is that there is to be no liability for death "resulting from the voluntary or involuntary taking of poison." Another, that the death must result within six months after injury, and result solely from bodily injuries effected solely by external, violent, and accidental means, and without intervening cause. Another, that there is no liability if the occasion of the accident be bodily infirmity. Still another, that there shall be no liability if the occasion of the accident be medical or surgical treatment. In addition to the matters set out by way of exhibits to the petition, the petition itself avers:—

"That said poison was accidentally taken, was neither voluntarily or involuntarily taken by him, but was the result of an accident as provided for in said certificate and the articles of incorporation and by-laws aforesaid."

(3) The demurrer which was sustained asserts that the petition shows on its face that the death was not caused by accidental means; was caused by a voluntary or involuntary taking of poison; or by an accident resulting from bodily infirmity; or by an accident resulting from medical treatment. It asserts the petition shows the death was caused by taking of poison, to wit, a drug administered by the physician of decedent, and taken voluntarily, or involuntarily, and that, therefore, the death was not produced by accidental means; asserts the petition shows that for some time before his death deceased was suffering from disease or bodily infirmity, and for that reason sought medical aid and took the drug, wherefore, it shows on its face that the accident was occasioned by disease or bodily infirmity; asserts it shows on its face death was produced by a drug given after consultation with reference to a sickness or bodily infirmity and seeking medical treatment—wherefore it shows on its face the accident was caused by medical treatment. Does the petition show this, on its face?

II. The words that single out the voluntary or involuntary taking of poison were put into the contract by the defendant, and it must be assumed they were intended to be effective, and state the exemptions of defendant to the uttermost extent intended. Therefore, they cannot mean that the naked fact of death by poison absolves from liability. It must have been intended there could be some deaths from poison for which defendant is liable. Had it been the intention that the mere fact that death was due to poison defeated recovery, a statement that the defendant was not liable if death so resulted would have been plenary and covered any death from poison, no matter how caused. If that was the intent, it is peculiar it should be effectuated by a provision that there should be an exemption if the poison was taken

voluntarily or involuntarily, which was merely the stating of part where all was intended. It follows that an admission which admits no more than that death may have been caused by strychnine is not an affirmative admission that the poison was taken either voluntarily or involuntarily. This follows because, as said, the very language of the contract recognizes that though there may be poisoning it may have been through poison which was taken neither voluntarily nor involuntarily.

If there be admissions that the death resulted from bodily infirmity, or medical treatment, and it did not result from external, violent, and accidental means, without intervening cause, it must be found in the statement of the brakeman, which is an exhibit to petition to this effect: Just before decedent went to the doctor he complained of a pain in his stomach; a few minutes after returning from the doctor decedent complained his legs were weak. He went into the coach and sat down. As he started out of the depot, and reached a window, he took hold of its ledge. Thereafter the brakeman and another took him by the arm and assisted him; decedent and the brakeman left on their train shortly after this, and Riley then complained of his legs hurting him, and wondered what the doctor had given him. When they got him on his feet he started to have convulsions and became unconscious; died in about an hour after he had seen the doctor. The further admission is that, in the opinion of Dr. Russ, the "injury itself, independent of all other causes, produced the death," and a statement that there were no marks upon the body or other external signs of injury. And a statement that there was such love of life, and of family, and such good health as to indicate that no poison was taken voluntarily. The admissions consist mostly of statements by persons who were not present when the decedent and Dr. Waud were together, to the effect that what they saw later indicates decedent had been poisoned by strychnine. This is a fair statement of this much because nothing appears concerning what decedent actually did in the drug store.

There are other things set out in the exhibits which require our consideration perhaps as much as those parts of the exhibit upon which defendant lays stress. There is a statement in the certificate of neighbor and friend that the cause of death was accidental poisoning, and a coroner's certificate that on legal inquest it was found deceased came to his death by accidental poisoning. The proof of loss, as much an exhibit as is the statement of the brakeman, says the accident happened from poison accidentally taken. Bearing in mind again that there may be poisoning other than by voluntary or involuntary taking of poison, it is no strain, in view of the rules prevailing in construing a contract framed by the defendant, that accidental poisoning is not the voluntary or involuntary taking of poison. In addition to the

matters set out by way of exhibits to petition, that pleading itself avers:—

"That said poison was accidentally taken, was neither voluntarily or involuntarily taken by him, but was the result of an accident as provided for in said certificates and the articles of incorporation and by-laws aforesaid."

We think the utmost that can be claimed from the matters set out by way of exhibit is that they have evidentiary force to sustain the ultimate proposition that death resulted from poison taken either voluntarily or involuntarily, or from bodily infirmity, or from medical treatment, and did not occur from bodily injuries effected solely by external, violent, and accidental means, and without intervening cause.

We have at the threshold, then, the question whether, if admissions made evidence of these things, they are not, on demurrer, controlled by an allegation of the petition that the death resulted from something other than what this evidence tends to show, and something which is covered by the contract of insurance. It is manifest that if on the trial the plaintiff made admissions which were evidence tending to defeat the suit, and defendant made a general admission that it was liable, the last would control the first. The first inquiry, then, is whether the demurrer did not, by admitting so much of the exhibits as assert accidental poisoning and admitting the allegation that the poison was accidentally taken, was neither voluntarily nor involuntarily taken, but was the result of an accident provided for in the certificate, articles of incorporation, and by-laws of defendant, admit away all that is admitted by the exhibits attached to the petition, which is to control, the admission of said parts of the exhibits and of the general allegation, or the setting out what may be deduced from other parts of the exhibits? This necessitates consideration of whether this general allegation in petition is well pleaded, for nothing else is admitted by demurrer. Our system of pleading is a fact system, and requires the parties to state truly and frankly the facts upon which they rely for their action or defense. It does not allow on the one hand the statement of legal conclusions, nor on the other hand the statement of evidence of facts; the pleading should state ultimate facts, and not the evidence of such facts. *Lumbert vs. Palmer*, 29 Iowa, 104; *Pfiffner vs. Krapfel*, 28 Iowa, 27; *Robinson vs. Berkey*, 100 Iowa, 136, 69 N. W. 434, 62 Am. Rep. 549. This makes the rule on what demurrer admits somewhat difficult of application. The demurrer will not admit a pure conclusion, and the pleader may not plead his evidence. All that the demurrer can ever admit then is something which states ultimate facts as distinguished either from legal conclusions or a setting out of the evidence to prove them. It follows that facts may be well pleaded within that rule, though what is pleaded has some of the aspects of a conclusion inter-

mingled with evidentiary allegations. We held in *Robinson vs Berkey*, 100 Iowa, at page 143, 69 N. W. 436 (62 Am. St. Rep. 549), as to an allegation that "defendants say that, with proper management, the said machine would not, and could not, and did not, do as much work, or as good work, as other machines of similar size, for the same purpose," and which it was moved to strike, that being in addition to facts upon which it was founded, the pleading satisfied the rule requiring a statement of facts; that while legal conclusions are not to be pleaded, and, likely, conclusions of fact may not be so stated as to be sufficiently plain, the test of the pleading is not whether it is so worded as to be unobjectionable were it a question to a witness. We are of opinion that if this general statement had stood alone, the petition would not have been vulnerable to demurrer, and demurrer would have admitted what is thus pleaded. It follows that admitting this admits the ultimate liability and right to recover and makes inoperative on demurrer the evidentiary matter set out in the exhibits to petition.

We add that the demurrer admitted the statement in exhibits that the death was due to accidental poisoning. We should not now decide, and do not, whether accidental poisoning is or is not the voluntary or involuntary taking of poison within the meaning of the provisions of this certificate. We hold the petition does not show affirmatively any of the defeasances upon which appellee relies. We are of opinion that there should be a trial on the petition, and that defendant may thereon show, if it can, that the death resulted from conditions which defeat recovery under the contract.

Reversed.



KANSAS CITY COURT OF APPEALS.

MISSOURI.

STROTHER

vs.

BUSINESS MEN'S ACCIDENT ASS'N OF AMERICA.*

1. INSURANCE—ACCIDENT INSURANCE—INJURY INTENTIONALLY INFILCTED—"ACCIDENTAL."

Under an accident insurance policy, providing that it should not cover any injury, fatal or otherwise, intentionally inflicted by any other person, the insurer was not liable where the death of insured directly resulted from a blow upon the head with a heavy wooden bar, intentionally inflicted by another, where such result was one reasonably to

* Decision rendered, July 3, 1916. 188 S. W. Rep. 314.

be apprehended from the use of such a weapon, without proof of any intent to kill insured, and notwithstanding the blow and insured's death might be "accidental" in the sense that as to him they were unforeseen, unexpected, and unusual, and did not take place according to the usual course of things, and were accidental in the usual, natural, and popular meaning of the word.

(For other cases, see Insurance, Cent. Dig. § 1184; Dec. Dig. § 464.)

(For other definitions, see Words and Phrases, First and Second Series, Accidental.)

2. INSURANCE—CONSTRUCTION OF CONTRACT.

In the construction of insurance contracts, that interpretation must be adopted which is most favorable to the insured; but this is so only where there is fair room for construction; and, if words are used clearly indicating the intention of the parties, effect must be given thereto.

(For other cases, see Insurance, Cent. Dig. § 295; Dec. Dig. § 146[3].)

Appeal from Circuit Court, Jackson County; O. A. Lucas, Judge.

Action by Sam B. Strother, administrator of the estate of Thomas Orie McCarty, deceased, against the Business Men's Accident Association of America. Judgment for defendant, and plaintiff appeals. Affirmed.

A. R. McClanahan, Jas. E. Taylor, and Reed & Harvey, all of Kansas City, for Appellant.

Gilmore & Brown, of Kansas City, for Respondent.

TRIMBLE, J.

Thomas O. McCarty held an accident policy issued by the defendant, an assessment accident insurance company organized under the laws of Missouri. In case of his death by accident, the policy provided for the payment of \$5,000 to his estate. However, it contained the following provision:—

"This policy does not cover * * * any injury, fatal or otherwise, intentionally inflicted by the insured (sane or insane) or by any other person (sane or insane) except it be established that the assault was committed for the sole purpose of burglary or robbery."

While the policy was in force, McCarty was struck a violent blow upon the head with a heavy wooden bar by one Cliff Dunford, from the effects of which insured died shortly thereafter. His administrator brought this suit to recover the amount of the policy. The company set up the above quoted provision of the policy, and alleged that insured—

"died of fatal injuries, intentionally inflicted upon him by another person, to wit, one * * * Cliff Dunford; that the said Cliff Dunford intentionally struck the said Thomas Orie McCarty a heavy and powerful blow upon the head with a piece of timber or lumber about two by four inches in width and thickness and about five feet in length, causing the fatal injuries from which the said Thomas Orie McCarty died."

The reply admitted that insured—

"was struck upon the head with a board by Clifford Dunford,

and received injuries thereby which proved fatal, but plaintiff denies that the said Dunford, when he struck deceased, intended to inflict a fatal injury."

At the close of all the evidence the court sustained defendant's demurrer thereto, and the plaintiff has brought the case here.

The circumstances leading up to and surrounding the infliction of the blow from which insured died are as follows: It occurred in a restaurant maintained in connection with a saloon in Kansas City. Late in the night of December 14, 1914, three women and three men were seated at a table in a restaurant. One of these women, Rose, had been living with insured, though they were not married. Two of the men were farmers, who had sold some horses to the third man, whose name was King, and the three had come to the restaurant at his suggestion. While thus seated at the table, two men, Cordell and Dunford, entered the room. Cordell approached one of the women, known as "Billie," and tried to get her to go home. Rose asked her to stay, and a quarrel started between Rose and Cordell. The latter, after using vile language, drew a knife and forced Rose to retreat toward the door. McCarty, the insured, was in the saloon and, learning in some way that Rose was in trouble, came through the street door into the restaurant to put Cordell out, either pushing him or knocking him out of the door. Rose at once shut the door and put her foot against it to prevent Cordell's return. McCarty, in the restaurant, turned around and was facing Dunford when the latter, having picked up a heavy wooden bar, a two by four, six feet long, and, holding it in both hands, drew it back over his head to an angle of 45 degrees so as to get "a full swing," and brought it down with all his force upon McCarty's head. McCarty dropped to the floor without uttering a word. He was unable to speak when one of the women tried to help him, being, as she said, "paralyzed." He was taken home, and died eight days later. When Dunford struck him there was no one between the two or close to them, and there is no room for any inference that Dunford, when he struck, was intending to do otherwise than to strike McCarty, the individual he did strike, though it is true the two men were strangers to each other. After felling McCarty, Dunford announced that he proposed "to clean up the place," and, approaching one of the farmers at the table, struck at him with the wooden bar. The latter, however, avoided the blow, and gave him "a poke in the jaw," which caused him to drop the bar. Thereupon Dunford and Cordell, who by this time had returned, began cutting the farmers with knives until in some way, not disclosed by the record, they ceased and left.

[1, 2] Under the restricted meaning given the term "accident" in policies of this character, the blow which McCarty received, and his death resulting therefrom, may be said to be accidental;

for as to him they were unforeseen, unexpected, and unusual, not taking place according to the usual course of things, and therefore were "accidental" in the usual, natural, and popular meaning of the word. *Lovelace vs. Travelers' Protective Ass'n*, 126 Mo. 104, 28 S. W. 877, 30 L. R. A. 209, 47 Am. St. Rep. 638. However, the decision in the case at bar does not turn upon whether the death was accidental, but upon another condition in the policy, which says it shall "not cover any injury, fatal or otherwise, intentionally inflicted by * * * any other person." The question is, Do the circumstances surrounding insured's death bring it within this exception to defendant's liability?

While it is true that in the construction of insurance contracts that interpretation must be adopted which is most favorable to insured, yet this is only where there is fair room for construction. If words are used which clearly indicate the intention of the parties, effect must be given thereto. Courts have no more right to remake insurance contracts than any others. Now, unquestionably McCarty's injury was inflicted by Dunford; and there is no room for any inference that the latter did not intend to inflict it. McCarty had just pushed or thrown Cordell out of the restaurant, and had turned back toward the body of the room and was facing Dunford when the latter, having picked up the bar as his companion was being put out, swung it back over his head so as to give it full force, and then brought it down upon McCarty's head. No one was about them. McCarty was the one he intended to strike, and the general "free for all fight" that plaintiff claims took place occurred after McCarty had been thus intentionally felled.

Neither is there anything giving rise to an inference that McCarty's death resulted from anything other than the blow itself. The blow was the direct, immediate, and proximate cause thereof with no untoward or unforeseen cause intervening between the blow and the death. For instance, the blow did not cause McCarty to fall and, in falling, receive an injury from which he died. In other words, the injury which Dunford intentionally inflicted caused the death of insured unassisted by any other cause. And the result which the blow produced was one reasonably and naturally to be apprehended from the use of such a weapon applied in the manner in which it was used.

The policy does not say the death of the insured must have been intended. The exception deals with any injury intentionally inflicted, whether that injury prove fatal or otherwise. Plaintiff insists that before defendant can claim exemption from liability, it must prove that Dunford intended to kill McCarty. But certainly Dunford intended to injure him, and the policy says that if the injury was intentionally inflicted, then that injury is not covered by the insurance no matter what the result of the injury may be, whether fatal or otherwise. The only case, of which

we are aware, which seems to give any countenance to the view that defendant must establish the fact that Dunford intended the precise and full extent of the result which followed his act is the case of *Utter vs. Travelers' Ins. Co.*, 65 Mich. 545, 32 N. W. 812, 8 Am. St. Rep. 913. In that case, however, the wording of the policy was that:—

The "insurance shall not be held to extend to * * * any case of death or personal injury, unless the claimant under this policy shall establish * * * that the said death or personal injury * * * was not the result of design," etc.

In other words, the exemption in the policy in that case dealt with two things, death or personal injury, and each must be the "result of design" in order to relieve the company. In that case a deputy sheriff was sent to a house of ill fame, with instructions to arrest a man therein as a deserter from the army. When he approached the door it was opened by insured, when the officer recklessly shot him, not knowing that he was the man to be arrested, but supposing that he was elsewhere in the house. The opinion on page 552 of 65 Mich. page 815 of 32 N. W. (8 Am. St. Rep. 913) says:—

"It seems to me that the design intended by the terms of this policy must be the design that intended the actual result accomplished, and not the design of the act itself, which act resulted in the killing of one contrary to the design of the act. If, when Berry fired this shot, he did not know the man he fired at was Utter, and did not intend to kill Utter, it cannot be said that Utter lost his life by the design of Berry."

The court also uses language throughout the opinion showing that the word "design" meant a plan previously formed in the mind and then intentionally carried out by the act. The words "result of design" are, however, vastly different from the words of the policy in the case at bar. Here the insurance does not extend to any injury "intentionally inflicted." This does not require the intention to go further than the blow inflicted nor is the policy considering results further than that the blow shall cause injury. The difference between the Utter Case and the case at bar is noted in the case of *Continental Casualty Co. vs. Cunningham*, 188 Ala. 159, loc. cit. 165, 66 South. 41; loc. cit. 42, L. R. A. 1915A, 538, where the court, speaking of the Utter Case, says:—

"That case, however, is decisively distinguished from the present case by the language of the policy there construed. The liability requirement that the death or injury of the assured should not be the result of design is obviously of narrower import than a requirement (as here) that it should not be the result of an intentional act. If the Utter Case is not thus distinguishable from this case, we are constrained to regard it as unsound."

The Cunningham Case also is authority for our holding that the fact that McCarty and Dunford were strangers is immaterial.

What difference does it make as to their acquaintance with each other? Dunford had been in the restaurant long enough to see what McCarty had done to Cordell, long enough to pick up the bar and form the intent to strike the individual before him, and he carried that intent into execution by striking the one he intended to strike. The injury McCarty received was therefore intentionally inflicted by Dunford, and that is all the policy requires to exempt the company. *Phelan vs. Travelers' Ins. Co.*, 38 Mo. App. 640, loc. cit. 646; *Jarnagin vs. Travelers' Protective Ass'n*, 133 Fed. 892, 66 C. C. A. 622, 68 L. R. A. 499; *Travelers' Protective Ass'n vs. Langholz*, 86 Fed. 60, 29 C. C. A. 628; *Matson vs. Travelers' Ins. Co.*, 93 Me. 469, 45 Atl. 518, 74 Am. St. Rep. 368; *General Accident, etc., Corporation vs. Stedman* (Tex. Civ. App.) 153 S. W. 692. We are of the opinion that the facts brought the case within the clause of the policy above quoted, and that the contract of insurance did not cover such injury. *Gaynor vs. Travelers' Ins. Co.*, 12 Ga. App. 601, 77 S. E. 1072; *Travelers' Ins. Co. vs. McConkey*, 127 U. S. 661, 8 Sup. Ct. 1360, 32 L. Ed. 308; *Travelers' Ins. Co. vs. McCarty*, 15 Colo. 351, 25 Pac. 713, 11 L. R. A. 297, 22 Am. St. Rep. 410; *Railway Officials', etc., Accident Ass'n vs. McCabe*, 61 Ill. App. 565; *Continental Cas. Co. vs. Fleming* (Ky.) 124 S. W. 331; *Travelers' Protective Ass'n vs. Weil*, 40 Tex. Civ. App. 629, 91 S. W. 886; *Fidelity & Casualty Co. vs. Smith*, 31 Tex. Civ. App. 111, 71 S. W. 391; *Continental Casualty Co. vs. Morris*, 46 Tex. Civ. App. 394, 102 S. W. 773; *Grimes vs. Fidelity & Casualty Co.*, 33 Tex. Civ. App. 275, 76 S. W. 811; *Ryan vs. Continental Casualty Co.*, 94 Neb. 35, 142 N. W. 288, 48 L. R. A. (N. S.) 524, Ann. Cas. 1914C, 1234; *Washington vs. Union Casualty, etc., Co.*, 115 Mo. App. 627, 91 S. W. 988.

We have examined the authorities cited by plaintiff, but in our opinion, owing to the difference in the wording of the policy and the facts surrounding the injury, they do not apply.

The judgment of the trial court is affirmed. All concur.



CONTINENTAL CASUALTY CO. *vs.* PITTMAN. (No. 593.)*

(Supreme Court of Georgia.)

INSURANCE—ACCIDENT INSURANCE—POLICY CONSTRUCTION—"EXTERNAL, VIOLENT, AND ACCIDENTAL MEANS." *Mrs. Caroline Pittman*, the mother of Herbert Pittman, recovered on the trial of a suit upon a policy of accident insurance issued by the

* Decision rendered, Aug. 18, 1916. 89 S. E. Rep. 716. Syllabus by the Court.

Continental Casualty Company. One clause of the policy provides for payments of indemnities set forth, for bodily injuries caused through external, violent, and purely accidental means; and another clause reads as follows: "If sunstroke, freezing, or hydrophobia, due in either case to external, violent, and accidental means, shall result, independently of all other causes, in the death of the insured within ninety days from date of exposure or infection, the company will pay said principal sum." The plaintiff was the beneficiary in the policy. The insured suffered a sunstroke on July 19, 1913, and died on that date. He was a railroad fireman, and occupied a position on the sunny side of the cab of an engine on a train running from Macon to Atlanta, Ga. The weather was very hot, and the insured was exposed to the sun and to the heat of the engine. Coming from Macon to Atlanta, he was almost continuously firing; he became overheated, and was taken with a high fever, and suffered a sunstroke, which had been produced by the extremely high heat to which he had been subjected in the performance of his duties.

The verdict in favor of the plaintiff was unauthorized, and should have been set aside. The death of the insured was from sunstroke, which overcame the decedent while he was performing his ordinary duties, in the ordinary way, upon a hot summer day; and there is nothing in the evidence to show that the sunstroke was due to "external, violent, and accidental means," within the meaning of those terms as employed in the policy sued upon. *Bryant vs. Continental Casualty Co.* (Tex. Civ. App.) 145 S. W. 636, and cases there cited.

(For other cases, see *Insurance, Cent. Dig.* §§ 1166-1169; *Dec. Dig.* § 455.)

(For other definitions, see *Words and Phrases. First and Second Series, External, Violent, and Accidental Means.*)

Error from Superior Court, Fulton County; W. D. Ellis, Judge. Action by Caroline Pittman against the Continental Casualty Company. There was a judgment for plaintiff, and defendant brings error. Reversed.

M. P. Cornelius and Manton Maverick, both of Chicago, Ill., and Robt. H. Jones, Jr., and Little, Powell, Smith & Goldstein, all of Atlanta, for Plaintiff in Error.

M. P. McWhorter and Edgar A. Neeley, both of Atlanta, for Defendant in Error.

CASUALTY, SURETY AND MISCELLANEOUS.

UNITED STATES CIRCUIT COURT OF APPEALS.

NINTH CIRCUIT.

MINERS' & MERCHANTS' BANK

vs.

UNITED STATES FIDELITY & GUARANTY CO.*

INSURANCE—LIABILITY INSURANCE—POLICY—CONSTRUCTION.

In 1906 defendant insured plaintiff bank from any and all loss or damage on account of wrongful acts of the cashier of a branch, by reason of fraud or dishonesty of such employee in connection with the duties of his office or position amounting to embezzlement or larceny committed during the continuance of the term or any renewal thereof, and discovered within such continuance or six months thereafter. As an inducement to be allowed to write the bond, defendant agreed to from time to time renew it without any additional cost, expense, trouble, or annoyance, and to save plaintiff bank harmless during the whole period. In 1913 a new bond insured the bank against any pecuniary loss growing out of any act of fraud, dishonesty, forgery, theft, larceny, embezzlement, wrongful abstraction, or misappropriation, or any criminal act, of the cashier of the branch bank. Defalcations and embezzlement by such cashier were not discovered until more than six months after the expiration of the last renewal of the 1906 bond. Held, that the bond of 1913 was not a renewal of the 1906 bond, the two bonds containing different conditions, and so no recovery for defalcations occurring prior to such bond could be had, on the theory that it renewed the original bond.

(For other cases, see Insurance, Dec. Dig. § 508½.)

In Error to the District Court of the United States for the Northern Division of the Western District of Washington; Jeremiah Neterer, Judge.

Action by the Miners' & Merchants' Bank, a corporation, against the United States Fidelity & Guaranty Company, a corporation. There was a judgment denying part of the relief sought, and plaintiff brings error. Affirmed.

Before Gilbert and Ross, C. JJ., and Rudkin, D. J.

John W. Roberts and George L. Spirk, both of Seattle, Wash., and William H. Metson, of San Francisco, Cal. (Metson, Drew & MacKenzie, of San Francisco, Cal., of counsel), for Plaintiff in Error.

Henry F. McClure and W. T. Dovell, both of Seattle, Wash. (McClure & McClure, of Seattle, Wash., and Hughes, McMicken, Dovell & Ramsey, all of Seattle, Wash., of counsel), for Defendant in Error.

* Decision rendered, July 3, 1916. 233 Fed. Rep. 654.

Ross, C. J.

This action was brought upon a policy of insurance issued by the defendant in error to the plaintiff in error on the 1st day of April, 1906, and which insurance the plaintiff alleged in its complaint was continued to April 1, 1914, by certain instruments in writing that are set out; the losses insured against being alleged to have been sustained by the plaintiff in the years 1911, 1912, and 1913, and not to have been discovered by the plaintiff until December 9th of the latter year. At the times in question the plaintiff in the action was a corporation of the state of Washington, and the defendant thereto a corporation of the state of Maryland; the principal place of business of the plaintiff being at Seattle, its president and director residing in that city, and doing a general banking business at Ketchikan, Alaska—one Mack A. Mitchell being its cashier there. The bond was executed by the defendant company at the request of the plaintiff, the employer of Mitchell, to secure the faithful performance of his duties. The amount of it was \$25,000, by its terms it was to expire April 1, 1907, and it was given in consideration of a premium of \$100, which was paid by the plaintiff. The loss insured against was:

"Such pecuniary loss as may be sustained by the employer by reason of the fraud or dishonesty of the said employee in connection with the duties of his office or position, amounting to embezzlement or larceny, and which shall have been committed during the continuance of said term, or of any renewal thereof, and discovered during said continuance, or of any renewal thereof, or within six months thereafter, or within six months from the death or dismissal or retirement of said employee from the service of the employer within the period of this bond, whichever of these events shall first happen."

Among the various provisions and conditions of the bond are the following:—

"Provided that, on the discovery of any act capable of giving rise to a claim hereunder, the employer shall, at the earliest practical moment, give notice thereof to the company, and any claim made under this bond shall be in writing addressed to the company at its head office in the city of Baltimore, and shall within three months after the discovery thereof, at the employer's expense, furnish to the company reasonable particulars and proofs of the correctness of said claim, and such particulars, if required, shall be verified by affidavit. * * * And provided, lastly, that this bond is also subject to the following conditions: That any misstatement or suppression of fact in any claim made hereunder renders this bond void from the beginning. This bond will become void as to any claim for which this company would otherwise be liable, if the employer shall fail to notify the company of the occurrence of the act or commission out of which said claim shall arise immediately after it shall come to the knowledge of the employer; and the knowledge of a president,

vice-president, director, secretary, treasurer, manager, cashier, or other like executive officer shall be deemed under this contract the knowledge of the employer. * * * That no one of the above conditions, or of the provisions contained in this bond, shall be deemed to have been waived by or on behalf of the company, unless the waiver be clearly expressed in writing over the signature of its president and secretary, and its seal thereto affixed. That the company, upon the execution of this bond, shall not thereafter be responsible to the employer, under any bond previously issued to the employer on behalf of said employee, and upon the issuance of any bond subsequent hereto upon said employee in favor of said employer, all responsibility hereunder shall cease and determine; it being mutually understood that it is the intention of this provision that but one (the last) bond shall be in force at one time, unless otherwise stipulated between the employer and the company. * * *

The complaint alleges, among other things, that as an inducement to be allowed to write the said bond of April 1, 1906, the defendant agreed:—

"That it would, at all times until such time as said bond should be canceled or terminated, keep the plaintiff bank wholly and fully insured and indemnified against any and all loss or damage on account of the wrongful act of said defendant Mack A. Mitchell, and represented to the plaintiff and did agree to and with the plaintiff that it would from time to time and from year to year cause said bond to be renewed, continued, and extended without any additional cost, expense, trouble, or annoyance to the plaintiff or its officers, except the payment of the annual premium, and would keep said bond in force and renewed, continued, and extended, and would keep the plaintiff fully insured and indemnified against loss or damage in connection with or on account of the wrongful act or conduct of said Mack A. Mitchell, its cashier."

It alleges, and it was conceded by the counsel of the respective parties at the trial, that the bond of April 1, 1906, was, without any formal application therefor, renewed six successive years by the defendant, and the annual premium of \$100 paid to it by the plaintiff; the certificate in each instance being similar except as to the dates, to the following one, issued April 1, 1910:

"Continuation Certificate No. T-450.

"Amount \$25,000.00. Premium, \$100.00.

"Fidelity Department.

"The United States Fidelity & Guaranty Company.

"Home Office, Baltimore, Maryland.

"In consideration of the sum of one hundred (\$100.00) dollars, the United States Fidelity & Guaranty Company hereby continues in force bond T-450 in the sum of twenty-five thousand (\$25,000) dollars on behalf of Mack A. Mitchell, in favor of Miners' & Merchants' Bank of Ketchikan, Alaska, for the period begin-

ning the 1st day of April, 1910, and ending on the 1st day of April, 1912 (1911), subject to all the covenants and conditions of said original bond heretofore issued dating from the 1st day of April, 1906.

"Witness the signature of its attorney in fact under corporate seal this 1st day of April, 1910.

"Douglas R. Tate, Attorney in Fact."

While the complaint contains the further allegation that the defendant continued to renew the said insurance from year to year until the 1st day of April, 1914, and that the plaintiff continued to pay the annual premium of \$100 until April 1, 1913, "when the premium was reduced to the sum of \$62.50," it alleges that on the last-mentioned day the defendant company executed to the plaintiff another bond in the same amount, on which the annual premium was \$62.50, by which latter bond the defendant guaranteed to pay to the plaintiff such pecuniary loss, subject to certain specified conditions, as it should sustain—

"by any act or acts of fraud, dishonesty, forgery, theft, larceny, embezzlement, wrongful abstraction, or misapplication, or misappropriation, or any criminal act by Mack A. Mitchell, directly or through connivance in any position and at any location in the employer's employ, and during the period commencing upon the date hereof and continuing in the sum of twenty-five thousand (\$25,000.00) dollars until the termination of this insurance."

Among its conditions are the following:—

"3. This insurance shall only terminate by: (1) The employer giving notice in writing to the insurer specifying the date of termination. (2) The insurer giving thirty (30) days' notice in writing to the employer. (The insurer to refund unearned premium in the above cases.) (3) The nonpayment of premium for a period of three (3) months beyond date due; all premiums being due in advance.

"4. The discovery of any loss through the employee."

Payment of the premium of \$62.50 on the last-mentioned bond is alleged in the complaint, which further alleges that it extended and continued in force the insurance theretofore existing to the 1st day of April, 1914. The complaint further alleges that on or about December 9, 1913, the plaintiff discovered certain facts in relation to the conduct of Mitchell which led it to believe that he had been guilty of acts which would give rise to a claim under the alleged contract of insurance, of which it immediately notified the defendant, and subsequently, to wit, on the 17th day of the same month of December, 1913, notified the defendant that Mitchell had been guilty of fraudulently abstracting from the plaintiff a sum of money in excess of \$25,000, and that said wrongful acts on the part of Mitchell began on or about May 15, 1913, and continued to and including August 14, 1913.

By its answer the defendant admitted the execution and deliv-

ery of all the documents as alleged in the complaint and the receipt by it of all of the premiums therein alleged, and set up, among other defenses, that the bond executed by it on the 1st day of April, 1906, and annually renewed to and including April 1, 1912, finally expired and terminated April 1, 1913; that the plaintiff did not within six months after April 1, 1913, or at any time prior to December 9, 1913, give notice to the defendant of the discovery of any act capable of giving rise to a claim under the bond of April 1, 1906, or under any renewal thereof, and did not at any time prior to December 9, 1913, make any claim in writing or otherwise against the defendant because of any of the alleged fraudulent or dishonest acts of the said Mitchell. The answer also alleges that at the time of the execution of the bond of April 1, 1906, and of its various continuations, the plaintiff agreed that it would from time to time make proper examination of the books of the bank to the ends that any misconduct on the part of Mitchell might be seasonably discovered, and that the bank failed to make such examination. The answer further pleaded in defense that the bond of April 1, 1913, was actually executed on or about November 25th of that year, when it was for the first time applied for by the plaintiff, and was dated back as of April 1, 1913, at the request of the plaintiff, and by means of false and fraudulent representations on its part.

To the latter allegation of the defendant the plaintiff replied to the effect:—

"That the last-mentioned bond was executed 'as and of the 1st day day of April, 1913, in pursuance of the agreement and arrangement between the parties hereto for the continuance in force of said fidelity insurance. * * * That the same was written and delivered by the defendant to the plaintiff as a part of and in pursuance of the agreement and arrangement existing between the parties hereto, * * * and for the consideration of the premium paid, and without any further or additional application having been made therefor. * * * That there was a slight delay in the execution and delivery of said bond, but that said delay was caused by the neglect of defendant, and without notice or knowledge on the part of plaintiff. That the same was caused through no fault or neglect of plaintiff, but was caused wholly through the fault, carelessness, and neglect of the defendant."

On the coming on of the case for trial a jury was impaneled, and opening statements made by the counsel of the respective parties, in which were stated the facts each expected to prove and an admission made by them of the fact that Mitchell wrongfully appropriated of the plaintiff's money during the year 1913, and after April 1st of that year, the amount for which the court below gave the plaintiff judgment; but the trial court refused to allow the plaintiff to make proof of any fraudulent appropriation by Mitchell prior to April 1, 1913, on the ground that the policy issued April 1, 1906, was finally terminated April 1, 1913, and

that no notice was given by the plaintiff to the defendant of any wrongful act on the part of Mitchell during the life of that policy, nor within six months after it expired, nor, indeed, was there any discovery by the plaintiff of any such act on the part of Mitchell within either of those periods.

The ground of the court's action was that the policy of date April 1, 1913, was a new and independent contract, and not a continuance of the pre-existing insurance. If correct in that conclusion, undoubtedly its judgment should be affirmed. But it is strenuously insisted by the plaintiff in error that the last policy was but a continuance of the pre-existing insurance, which the complaint alleges the defendant agreed to renew annually as an inducement to be permitted to write the original insurance, and that that question, as well as that respecting the fraudulent representations alleged by the defendant to have been made by the plaintiff in the matter of procuring the policy issued in November, 1913, as of date April 1st of that year, were questions for the determination of the jury, and that the court below therefore erred in taking the case from the jury, and awarding the plaintiff judgment only for the amount the parties agreed Mitchell misappropriated subsequent to April 1, 1913. If those issues could be held to be material matters of fact under the pleadings and admissions of the parties, beyond doubt the contention on behalf of the plaintiff in error would be well founded and the judgment should be reversed; for in that view they would plainly be questions for the determination of the jury. But the present action is based on written instruments, and unless the bond executed in November, 1913, as of date April 1st of that year, can be properly held to be a continuation of the policy of April 1, 1906, it manifestly was, as the trial court held, a new and independent contract of insurance. Comparing the two, it is readily seen that they are essentially different. Not only does the later policy make no reference to the former insurance, which by its terms expired April 1, 1913, but the subject-matter of the two is essentially distinct. By the policy of April 1, 1906, the defendant company made itself liable only for such acts of Mitchell as amounted to "embezzlement or larceny," whereas, under the policy issued as of date April 1, 1913, it became liable to the plaintiff for such pecuniary loss sustained by it growing out of "any act or acts of fraud, dishonesty, forgery, theft, larceny, embezzlement, wrongful abstraction or misapplication, or misappropriation, or any criminal act by Mack A. Mitchell, directly or through connivance, in any position and at any location in the" plaintiff's employ, which insurance was made to continue, not for one year only, or for any definite time, as the former policy did, but until terminated in the method therein specified.

The judgment is affirmed.

SUPREME COURT OF NEW YORK.**APPELLATE TERM, FIRST DEPARTMENT.****LAWRENCE****vs.****MASSACHUSETTS BONDING & INS. CO.*****1 INSURANCE—ACTIONS—LIMITATIONS—PROVISIONS OF POLICY.**

Where an insurance company, which, by its policy, has agreed to indemnify insured against liability for damages suffered by any person by reason of work prosecuted on the premises of insured, and to defend any suit, even if groundless, refuses to defend a suit against insured, an action for breach of the contract by such refusal is not governed by a provision of the policy that no action shall lie against the company for any loss or expense under the policy, except after trial of the issue and within ninety days after payment of the loss or expense.

(For other cases, see Insurance, Cent. Dig. §§ 1540, 1544; Dec. Dig. § 622[1].)

2. INSURANCE—ACTIONS—DIRECTION OF VERDICT—SETTING ASIDE VERDICT.

Where insured in a liability policy, after refusal of the insurer to defend a claim against him for \$5,000, and after suit brought, but before trial, settled the claim by a payment of \$500, and paid his attorney \$100, which was conceded to be a reasonable fee, and in an action against the insurer for breach of the contract to defend insured the court, on motion of both parties for directed verdict, directed a verdict for the insured for \$600, though there was no proof of liability of the insured, it was error to set aside the verdict rendered pursuant to such direction.

(For other cases, see Insurance, Cent. Dig. § 1665; Dec. Dig. § 646[8].)

Appeal from Municipal Court, Borough of Manhattan, Fifth District. Action by Gustavus L. Lawrence against the Massachusetts Bonding & Insurance Company. From a judgment for defendant, dismissing the complaint on the merits, and from an order setting aside a verdict directed for plaintiff, plaintiff appeals. Reversed, and verdict reinstated.

Argued March term, 1916, before Lehman, P. J., and Pendleton, and Whitaker, JJ.

Sydney W. Stern, of New York City, for Appellant.

Alfred E. Holmes, of New York City (F. H. J. Maxwell, of New York City, of counsel), for Respondent.

LEHMAN, J.

On April 22, 1913, the defendant agreed to indemnify the plaintiff for liability for damages on account of bodily injuries suffered by any person by reason of certain work which was to be prosecuted on premises owned by the plaintiff. The defendant also agreed to defend any suit, even if groundless. The policy contained a provision that:—

* Decision rendered, July 7, 1916. 160 N. Y. Supp. 883.

"No action shall lie against the company to recover for any loss or expense under this policy unless it shall be brought by the assured for loss or expense incurred and paid in money by the assured, after trial of the issue; nor unless such action is brought within ninety days after the payment of such loss and expense."

At the trial it appeared that the plaintiff's watchman was injured by a fall into a hole on the premises left by a contractor engaged in the prosecution of the work described in the policy of insurance. The watchman died as a result of the injuries. His administratrix then began suit against the plaintiff, and the insurance company refused to defend the suit on the ground that the accident was not covered by the policy of the insurance. Thereafter, on the 30th day of December, 1913, the plaintiff, upon the advice of his counsel and with the approval of the surrogate, compromised the said action by payment of the sum of \$500. On December 7, 1915, the plaintiff started the present action for breach of the defendant's agreement to defend the action, claiming that the damages for such breach are the sum of \$500, paid in settlement of the original action, and \$100 counsel fee, paid therein. The defendant conceded at the trial that the counsel fee was reasonable, but no proof was presented to show that the plaintiff was actually liable in the negligence action. At the close of the trial both sides moved for the direction of a verdict, and the learned trial justice directed a verdict for the plaintiff, but reserved decision on the motion to set aside the verdict. Thereafter he set aside the verdict and dismissed the complaint, on the ground that the action was not brought within ninety days after the payment of the loss and expense. The defendant now seeks to sustain the judgment of dismissal on various grounds, but I think that only two of the contentions raised require serious consideration, viz., that the plaintiff has presented no evidence that he was liable to the administratrix of the deceased, and that the action was not brought within the time limited by the contract.

[1] In determining the rights of the parties in this action it seems to me that the most important consideration is that the action is not brought to enforce the agreement to indemnify the plaintiff for loss and expenses, but is brought for damages for failure to defend an action. The defendant agreed to defend all actions, even an action which is groundless. It broke this agreement, and is liable for the damages caused by its breach. This action is brought for these damages. In addition, the defendant insured the plaintiff against "loss from the liability imposed by law upon the assured for damages on account of bodily injuries suffered" in certain cases; but this action is not predicated upon the express agreement of the defendant to pay the loss and expenses caused by an accident covered by the policy. The limitation in the policy is, I think, by its plain terms intended to cover an action for such loss and expenses, and is not intended to cover an

action for damages caused by the breach of the covenant to defend. Inasmuch as the limitation applies only to actions brought to recover any loss or expense "under this policy," against which the defendant expressly agreed to indemnify the plaintiff, while this action is brought to recover damages for breach of contract to defend, the present action is subject only to the limitation of the statute, and not to any limitation provided in the contract. In other words, I think that a fair construction of the contract is that the defendant agreed to pay any loss or expense, and provided the manner in which such loss or damage must be proven, and a limitation of actions to prove such loss or damage. It has itself made it unnecessary, if not impossible, by its own wrongful act, for the plaintiff to prove the damages in the manner agreed upon. The contract never contemplated that the defendant would breach its contract, and it contains no provisions for an action for such breach of contract. Such an action, consequently, is governed by the ordinary rules of law governing actions for breach of contract.

[2] The same considerations in my opinion must determine the question of whether, in such an action, the plaintiff must prove that he was liable to the administratrix of the deceased. In the case of Mayor, Lane & Co. vs. Commercial Casualty Ins. Co., 169 App. Div. 772, 155 N. Y. Supp. 75, the Appellate Division reversed a judgment for the amount paid in settlement of a claim, where the defendant had also wrongfully refused to defend, holding that:—

"When * * * the assured saw fit to settle before a recovery, he assumed the risk in an action against the insurer of showing not only a liability covered by the policy but the amount of the liability."

The rule of law there announced is clearly binding upon us, if it is applicable to the present case. The opinions in that case show, however, that the court construed the action as one to enforce the covenant to indemnify, and not as an action for breach of contract to defend. The effect of the covenant to defend was considered only in its bearing upon the question of whether the defendant, by breaching this covenant, had waived any benefit of the clause precluding the plaintiff from settling an action, and the opinion of the Appellate Division must be read in the light of the question considered by it. In the present case, however, as pointed out above, the action is for this breach. There can be no question but that such an action would lie, even if the contract contained no covenant of indemnity. In such an action the plaintiff is entitled to recover his proximate damages. There can be no question that the reasonable value of the services of an attorney in defending the original action are proximate damages for the defendant's failure to defend the action itself. In this case the services of the attorney up to the time of the settlement were concededly worth \$100.

There remains, however, the question whether the amount paid upon the settlement was also proximate damages. In the case of St. Louis Beef Co. vs. Casualty Co., 201 U. S. 173, at page 182, 26 Sup. Ct. 400 at page 404 (50 L. Ed. 712), the court stated:—

"We assume that the settlement was reasonable, and that the plaintiff could not * * * escape at less cost by defending the suits. If this were otherwise, no doubt the defendant would profit by the fact. The defendant did not agree to repay a gratuity, or more than fairly could be said to have been paid upon compulsion. But a sum paid in the prudent settlement of a suit is paid under the compulsion of the suit as truly as if it were paid upon execution."

As I read this case, as well as the various cases in New York, in which this question has been considered and the doctrine of the federal decision followed (*Mayor, Lane & Co. vs. Commercial Casualty Insurance Co.*, *supra*; *Matter of Empire State Surety Co.*, 214 N. Y. 553, 108 N. E. 825), the true rule is that, where a settlement is made after failure of the insurance company to defend the action the insured is entitled to recover the amount paid in settlement of the action only upon proof of actual liability, where the amount paid is more than the reasonable and probable cost of defending the action but may recover the amount so paid without such proof where the settlement is no more than the reasonable cost of defending the action, even though the insured would be ultimately not liable. In the one case the claim against the insurer would obviously be for indemnity; in the second case, the claim for damages would obviously be for the damages directly caused by the failure of the insurer to defend the action. In this case, therefore, the real question is whether there is any evidence in this case that the settlement of the action brought by the administratrix was a reasonable settlement of a groundless action.

Upon this point the evidence showed that the deceased met his death by negligence for which it was claimed that the plaintiff was responsible. We must therefore assume that the administratrix would have recovered substantial damages if the insured had been responsible, and the amount of possible liability would be one element in determining the value of the attorney's services in defending such an action. It was also conceded that the reasonable value of the services of the attorney without a trial was \$100. It seems to me that under these circumstances we have a right to infer that the services of an attorney upon the trial and upon a possible appeal would be reasonably worth \$500 in addition. Certainly, if the court upon these facts were asked to approve in advance of a contract by which a defendant in a negligence action agreed to pay his attorney the sum of \$600 for all proceedings in the action until its final determination, it would be justified in holding such a contract reasonable. If in this case

we should sustain the defendant's contention that actual liability in the negligence action must be shown, then it follows that an insured, who has a contract by which an insurance company agreed to defend all actions, even though groundless, must go to the trouble and expense of actually defending the action until its final determination or lose the benefit of the insurance company's covenant to defend the action.

The order setting aside the verdict should therefore be reversed, and the verdict reinstated, with \$30 costs of the appeal.

PENDLETON, J. (concurring).

[1] The cause of action set forth in the complaint is for damages for breach of the covenant to defend, and I quite agree that this is not an "action to recover for loss or expenses under the policy," and therefore not within the provisions of clause E of the policy, and is governed by the usual rules of law relating to actions for breach of contract, and the order setting aside the verdict must therefore be reversed.

[2] A cause of action for failure to pay the loss and expenses may be joined with one for breach of covenant to defend. To recover on such a cause of action, if a settlement has been made, the plaintiff must prove the liability. *Mayor, Lane & Co. vs. Commercial Casualty Insurance Co.*, 169 App. Div. 772, 155 N.Y. Supp. 75. But, where the action is only for breach of covenant to defend, the measure of damages is the cost of defending. What this would be is a question for the jury, and it is not permitted to speculate as to what such amount might be or the jury might have found. The amount paid in settlement is immaterial, except that in no event could plaintiff recover more than he paid out. The direction of a verdict for plaintiff was therefore error and the verdict should not be reinstated, if defendant is in a position to raise this question, but a new trial should be ordered. Both parties, however, having moved for the direction of a verdict, defendant, not having asked to have the question of the amount of damages submitted to the jury, must be held to have conceded that there was no question of fact involved, and cannot now be heard to the contrary.

Order setting aside the verdict reversed, and verdict reinstated, with \$30 cost of appeal.

WHITAKER, J. (concurring).

Plaintiff was having a building constructed in the Bronx, and defendant had issued to him a policy of insurance against accident. The work was being done by contractors. Plaintiff had a watchman on the work, but no other employees. The contractor left an open hole on the work, into which the plaintiff's watchman fell and was killed. The administratrix of the deceased watchman made a claim against plaintiff for damages based upon his alleged negligence. Plaintiff duly notified the defendant of the accident and claim, and requested it to take charge of the

case and defend it according to the terms of its policy of insurance. The defendant absolutely repudiated all liability and refused to take charge, defend, or take any steps whatsoever in the matter. Thereafter the administratrix of the deceased watchman commenced an action against plaintiff and served him with a summons in the Supreme Court. Plaintiff interposed no answer, but settled the action, with the approval of the Surrogate's Court, by the payment of \$500 to the administratrix and the sum of \$100 to plaintiff's attorney therein for his services. Defendant concedes this \$100 was a reasonable payment.

The final settlement was made, and the money was paid to the administratrix and to plaintiff's attorney, on January 3, 1914. This action was not begun until December, 1915. The defendant bases its defense upon three grounds: First, that the plaintiff was not justified under the terms of the policy in settling the claim, and was required to show on this trial the legal liability of the defendant and the reasonableness of the sum paid in settlement; second, that there was a breach of warranty by reason of plaintiff having represented that he had no employees upon the work; third, that the plaintiff was required in any event to begin his action within ninety days after the money in settlement had been paid.

The provisions of the policy in so far as they are material provided as follows:—

"In consideration of the premium herein provided, the Massachusetts Bonding & Insurance Company of Boston, Massachusetts (called the company), hereby agree to indemnify the assured referred to in the schedule of warranties, and subject to the limits hereinafter provided for, against loss from the liability imposed by law upon the assured for damages on account of bodily injuries, including death resulting therefrom, accidentally suffered by any person or persons whomsoever, by reason of the prosecution of the work described in the schedule, and caused by the negligence of any contractor or subcontractor, engaged in such work, or any part thereof, provided such bodily injuries or death are suffered as the result of accident within the period stated in the schedule."

"B. It is agreed that all work mentioned in the schedule is to be done by written contract at the risk of the contractor or contractors, and that the assured has not and will not by contract or otherwise voluntarily assume any liability for loss on account of injuries or death suffered by any person or persons. It is agreed that no employee of the assured shall be engaged on work in the premises herein described, except watchman caring for premises and material, nor shall the assured furnish any material or appliances, or assume any supervision of the work herein described, unless an agreement to the contrary is specifically indorsed thereon."

"D. If thereafter any suit, even if groundless, is brought

against the assured to enforce a claim for damages on account of an accident covered by this policy, the assured shall immediately forward to the company every summons or other process as soon as the same shall have been served on him, and the company will, at its own cost, and subject to the limitations contained in condition O hereof, defend or at its option settle such suit in the name and on behalf of assured."

"E. No action shall lie against the company to recover for any loss or expense under this policy, unless it shall be brought by the assured for loss or expense incurred and paid in money by the assured, after trial of the issue, nor unless such action is brought within ninety (90) days after the payment of such loss or expense; but if any provision of this condition is in conflict with the statutes of any state within which this policy covers, the condition shall be inoperative within such states, in so far as the statutes conflict with such provision."

"Q. The following warranties, numbered 1 to 10, inclusive, are hereby made a part of this contract, and are acknowledged and warranted by the assured to be true upon the acceptance of this policy, except such as are declared to be matters of estimate only:—

"Warranties.

"(1) Name of assured: Gustavus L. Lawrence.

"[Description of property and unnecessary warranties omitted.]

"7. No employee of the owner is engaged in any work on the premises herein described, except as follows: No exceptions."

[2] As to the first point raised by the defendant, it should be kept in mind that the defendant was required under the terms of its policy to defend suits brought against plaintiff, even if such suits were groundless. So that its obligation to defend the plaintiff did not depend upon the question of plaintiff's legal liability in such suit. This takes the present case out of the line of cases similar to *Cornell vs. Travelers' Insurance Co.*, 175 N. Y. 239, 67 N. E. 578, which holds that the insurance company generally is only required to defend suits where there is a legal liability on the part of the insured, and that such policies only cover cases where there is such legal liability. I think it follows, therefore, that defendant's refusal to comply with the plaintiff's request to defend or take charge of the claim made against the plaintiff was a complete violation and repudiation of its contract.

This being so, the defendant waived its right to insist upon an actual trial of the issues, in the suit brought against the plaintiff. It was fully in its power to have had such a trial, it was actually requested to do so, and it refused. Defendant should not, therefore, be allowed to take advantage of its own wrong to the disadvantage of the plaintiff, who upon his part had fully lived up to the terms of the contract. The foundation of defendant's defense in this respect is based upon its own wrong. As was held in the case of *Cornell vs. Travelers' Insurance Co.*, supra,

the defendant, by refusing to defend the suit, took its chances of any future liability that might be imposed upon the plaintiff. The defendant waived its right to insist upon a suit and judgment determining the amount of liability. Mayor, Lane & Co. vs. Commercial Casualty Co., 169 App. Div. 772, 155 N. Y. Supp. 75; Matter of Empire State Surety Co., 214 N. Y. 553, 108 N. E. 825.

There was only one other manner in which to determine the amount and liability of plaintiff and that was by the plaintiff using a reasonable care and discretion in such determination, and I think the facts disclosed by the record are ample to show that such reasonable care and discretion were used. At least there was, in my opinion, ample proof shown upon the trial to have cast the burden upon the defendant of showing the settlement was not a proper one. It would certainly be impracticable, if not impossible, upon this trial for the plaintiff to establish his legal liability in the action brought against him by the administratrix of Filardo, the decedent. He admitted his liability after advice of counsel, and if the defendant waived the right to have plaintiff's liability settled by a trial in that action there is no reason why the waiver should not apply to this action. If there was a waiver (and the Appellate Division and Court of Appeals have held there was), the right waived must have been the right to have the liability and amount settled by a judgment of a court of law. To hold that in this action such a legal liability must be determined by a judgment of the court would in effect be to hold that there was no waiver.

I do not think, therefore, that when the court in the case of Mayor, Lane & Co. vs. Commercial Casualty Co., *supra*, used the phrase, "When, however, the assured saw fit to settle before recovery, he assumed the risk in an action against the insurer of showing, not only a liability covered by the policy, but the amount of the liability," it meant to hold that such liability and the amount thereof must be determined by requiring the plaintiff in this action to virtually try the case against himself in the other action in the same manner that it would have been tried had no settlement been made. To quote the phrase used by Mr. Justice Holmes, and which was approved by the Court of Appeals in the Matter of the Empire State Surety Co., *supra* :—

"The defendant by its abdication put the plaintiff in its place with all its rights."

I think, therefore, the plaintiff was justified in settling the claim, and that there was sufficient evidence to show plaintiff's legal liability, and that the amount paid on the settlement was a reasonable amount, and that the plaintiff used sufficient care and discretion in the settlement, to sustain the verdict directed by the court.

Concerning the second ground of defendant's defense, that there was a breach of warranty by reason of plaintiff having

represented that there were no employees: The body of the policy expressly states that it was agreed that no employee of the assured shall be engaged in work in the premises described "except watchman caring for the premises and material." This provision expressly eliminates watchmen, and shows clearly a plain intention to exclude watchmen from the term "employees." Furthermore, there was no evidence that at the time the policy was issued there was a watchman on the premises employed by plaintiff. Therefore the warranty may have been perfectly true when made, and it only relates to the time when made. *Mayor, Lane & Co. vs. Commercial Casualty Co., supra.* I do not think that this defense is maintainable.

[1] The third defense, which alleges plaintiff's failure to bring his action within 90 days after the money in settlement had been paid, is a more plausible one, concerning which differences of opinion may well be maintained. This action as matter of fact was not brought until about a year after the payments in settlement of the suit against plaintiff by Filardo's administratrix were made, and the learned justice of the Municipal Court has written a strong opinion holding that the ninety-day limitation was in force and applicable, and barred the plaintiff from bringing this action. I am unable to agree with the learned justice for the following reasons:—

My first reason for differing with him is that the decisions of the Court of Appeals and the Appellate Division are direct authority for holding that there was a clear waiver of the requirement that there should be a trial of the issues, and if a trial of the issues was waived it seems to me for the same reason the limitation of ninety days was waived; it being in pari materia.

My second reason is I do not agree with the construction given the policy by the Municipal Court. The provision in question is paragraph E of the policy and reads as follows:—

"No action shall lie against the company to recover for any loss or expense under this policy, unless it shall be brought by the assured for loss or expense incurred and paid in money by the assured, after trial of the issue, nor unless such action is brought within ninety days after the payment of such loss or expense."

There are certain well-recognized rules of interpretation and construction which apply and which must be observed: First, the intention of the parties must govern, if ascertainable; second, the contract having been drawn by the defendant, it must be construed most strongly against it; third, insurance contracts, where there is any ambiguity, must be given a meaning most favorable to the assured. The actual reading of this clause shows that no provision is made for money paid in settlement of a claim, unless the "issues have been tried," and discloses clearly that there is no limitation placed upon actions to recover for loss or expense, where there has been no "trial of the issues." As matter

of fact it is perfectly clear that the defendant never intended that there should be any such limitation, because it expressly repudiates the claim that an action is maintainable at all where there has been no such trial. And the defendant is inconsistent when it says, under the terms of the policy, no action will lie to recover for a settlement where there has been no "trial of the issues." Nevertheless you must, under the terms of the policy, bring such an action within ninety days. The policy contains no ninety-day limitation which is applicable to the case at bar, and the defendant never intended that it should contain any such limitation. Its limitation is only against actions to recover "loss and expenses" where there has been a "trial of the issues."

Inasmuch, however, as there is apparently considerable divergence of opinion upon the proper construction to be placed upon this provision, two courts and two able members of the bar having differed, under the rules of interpretation above referred to, the question should, I think, be resolved in favor of the appellant, and that the order should be reversed, with \$30 costs to appellant, and the verdict in favor of plaintiff reinstated, with costs.

PHILADELPHIA PICKLING CO. vs. MARYLAND CASUALTY CO.*

(Court of Errors and Appeals of New Jersey.)

1. INSURANCE—ACTIONS ON POLICIES—CONTRACTUAL LIMITATIONS—"PAID AND SATISFIED."

"Paid and satisfied" in a manufacturer's employer's liability policy of insurance, as applied to a judgment, mean when the judgment is fully paid. The judgment to be paid and satisfied does not necessarily mean canceled of record.

(For other cases, see Insurance, Cent. Dig. § 1298; Dec. Dig. § 514.)

2. INSURANCE—RIGHT TO PROCEEDS—ASSIGNMENT OF POLICY.

There is no legal liability of an insurance company to a corporation other than the assured, to whom the policy has been transferred by the assured, after the policy under its terms had expired, under an agreement by which the assets and liabilities of the assured were transferred to the new corporation.

(For other cases, see Insurance, Cent. Dig. §§ 488, 489, 494-496; Dec. Dig. § 219.)

Appeal from Supreme Court.

Action by the Philadelphia Pickling Company against the Maryland

* Decision rendered, June 19, 1916. 98 Atl. Rep. 433. Syllabus by the Court.

Casualty Company. From judgment for defendant plaintiff appeals. Affirmed.

(See, also, 94 Atl. 889.)

Wilson & Carr, of Camden, for Appellant.
Richard F. Jones and Marshall Van Winkle, both of Jersey City, for Appellee.

GRIFFITH *vs.* FRANKFORT GENERAL INS. CO.*

(Supreme Court of North Dakota.)

1. INSURANCE—LIABILITY INSURANCE—RECOVERY FROM INSURER.

Plaintiff, through contractors, erected a building safeguarding against liability for negligent injuries to workmen by employers' liability insurance taken of defendant company. One Westby was injured while working on said building, and made a claim of plaintiff for injuries and for wages during lost time. Defendant's claim agent settled with Westby. Plaintiff alleges it retained \$150 for him, deducted from Westby's claim, and which amount plaintiff had advanced the laborer pending settlement. Defendant claims it settled for \$150 less than the claim presented, and made no agreement with Westby to reimburse plaintiff for his advances to Westby. Verdict in plaintiff's favor. Defendant appeals. *Held*, the evidence was sufficient to justify submission to the jury, and sufficient to support the verdict.

(For other cases, see Insurance, Cent. Dig. §§ 1723, 1724, 1726, 1727; Dec. Dig. § 665[7].)

2. INSURANCE—AUTHORITY OF AGENT—RATIFICATION.

Though the claim agent was without actual authority to make settlement found by the jury to have been made, defendant could waive any want of authority and ratify the settlement, and has done so by failing to repudiate it.

(For other cases, see Insurance, Cent. Dig. § 1412; Dec. Dig. § 565.)

3. INSURANCE—FORFEITURE—EMPLOYERS' LIABILITY INSURANCE—ADVANCE BY INSURED.

It cannot avail of a favorable settlement with Westby, relieving it from liability on its insurance contract and at the same time keep money it agreed on said settlement with Westby to pay to Griffith, under claim that under the contract it could have defended and refused to have paid anything, because Griffith advanced said \$150 in violation of its insurance contract.

(For other cases, see Insurance, Cent. Dig. §§ 1417, 1419; Dec. Dig. § 579.)

4. INSURANCE—FORFEITURE—ESTOPPEL.

By recognizing its responsibility under the insurance policy by settling with Westby thereunder, it waived any right to avoid the same to defeat

* Decision rendered, July 28, 1916. 159 N. W. Rep. 19. Syllabus by the Court.

payment to plaintiff of the money it received in such settlement for him.

(For other cases, see *Insurance*, Cent. Dig. § 1085; Dec. Dig. § 399.)

Appeal from District Court, Grand Forks County; Cooley, Judge. Action by R. B. Griffith against the Frankfort General Insurance Company. From a judgment for plaintiff, defendant appeals. Affirmed.

Murphy & Toner, of Grand Forks, for Appellant.
H. A. Bronson, of Grand Forks, for Respondent.

LIFE.

SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FIRST DEPARTMENT.

LOCKWOOD, EXR. OF RICHARD A. CANFIELD, DECEASED,
Respondent,

v.s.

NEW YORK LIFE INSURANCE COMPANY, Appellant. (No. 220.)*

Appeal from a judgment at Trial Term entered on a decision, a jury having been waived, for \$34,047.21, on a life insurance policy. Reversed.

James H. McIntosh of Counsel (Louis H. Cooke with him on the brief), for Appellant.

Robert L. Redfield of Counsel (Richard P. Lydon with him on the brief), for Respondent.

CLARKE, P. J.

On December 5, 1899, the defendant issued its policy No. 997-228, insuring the life of Richard A. Canfield, and therein agreed, in consideration of the payment of the sum of \$7,579 and a like sum on the fifth day of December in every year during the continuance of the policy until twenty full years premium should be paid, to pay an amount not to exceed \$124,000, as specified in a table contained therein, upon receipt and approval of proofs of Canfield's death. Thereafter the annual premium was duly reduced to \$7,277.

The policy was written on what was called the insurance bond, accumulation plan, with a twenty-year accumulation period, and in addition to insurance and loan benefits it provided for participation in the profits of the defendant if the insured was living and the policy in force on the 5th of December, 1919.

The amount of insurance payable in the event of death gradually decreased with the age of the policy from \$124,000 during the first seven years to \$117,500, during the twentieth year.

The policy provided for loans as follows: "Cash loans can be obtained on the sole security of this insurance bond on demand at any time after this bond has been in force two full years, if premiums have been duly paid to the anniversary of the insurance next succeeding the date when the loan is made. Application for any loan must be made in writing by the insured to the home office of the company, and the loan will be subject to the terms of the company's loan agreement. The amount of loan available at any time is stated in column 2 below, and includes any previous loans then unpaid. Interest will be at the rate of 5 per cent per annum in advance."

* Decision rendered, October, 1916. From a certified transcript.

The amount of loan available gradually increased with the age of the policy from \$3,400 after the expiration of the second year to \$117,500 after the expiration of the nineteenth year.

On the 7th day of January, 1914, said Canfield obtained from defendant a cash loan of \$79,452 on the pledge of the policy as security therefor as evidenced by his loan agreement. In the loan agreement Canfield agreed to pay interest at 5 per cent in advance to the next premium payment date of the policy, namely, December 5, 1914, and annually in advance thereafter, and he further agreed to pay the amount of said loan when due, with interest, reserving the right to reclaim the policy by repaying the loan with interest at any time before due, but the loan did not become due and payable unless there was default in the payment of premium or interest, "or, (1) on the maturity of the policy as a death claim or an endowment; (2) on the surrender of the policy for a cash value; (3) on the selection of a discontinuing option at the end of any dividend period. In any such event the amount due on said loan shall be deducted from the sum to be paid or allowed under said policy."

A few days before December 5, 1914, Canfield called at the defendant's home office and saw the defendant's Second Vice-President, John A. McCall, and told him that he wished to confer with him about his policy. Mr. McCall then referred Canfield to defendant's Assistant Secretary, Wilbur H. Pierson. Canfield stated to Pierson that he desired, if possible, to have the twenty-year accumulation period under the policy shortened to a fifteen-year period or, if the defendant was unwilling to do this, he desired to surrender the policy for its value in cash. That he asked Pierson to write him and tell him exactly what the defendant would do. On December 7, 1914, Pierson, as requested by Canfield, wrote to him as follows:—

"I have consulted with the officers of the company with reference to shortening the dividend period of your policy to fifteen years, and I find this cannot be done now for the reasons I stated to you during your recent visit to this office. The present cash surrender value of your policy is \$89,900, from which amount the outstanding loan would be deducted."

On December 8, Canfield wrote to Pierson as follows:—

"I have your note stating surrender value of my policy to be \$89,900. Also that the company cannot recognize my request for a dividend period of fifteen years.

"I am disappointed at the decision, and am unable to see the equity of refusing to a client who has paid fifteen premiums, what you would give had he paid but fourteen.

"As a matter of plain finance, my policy has no value now. Any value it may have had, has been gradually lost as the fifteen years passed. To pay five years more premiums with fifteen years' interest on a premium, would compel me to pay more

money by far than I would get, and I would also lose my principal, as explained to you. Therefore, I will thank you to send me a check for the surrender value of my policy, less my loan from the company."

The \$89,900 offered for the policy "less my loan from the company" left a net sum of \$10,448.

On December 9th, after receiving Canfield's letter of December 8th, the company wrote to him as follows:—

"Concerning the payment of the surrender value of your policy.

"Company's check in payment of the full cash value of your policy will be ready for delivery to you tomorrow, at such time as you may designate. If you prefer to come to the home office, check will be held here awaiting your call. If you prefer to have it delivered to you and will call me on the 'phone indicating the time suiting your convenience, we will have a representative of this department call upon you, tender the check and obtain your release." And thereupon on December 9th, the defendant drew a warrant for its check for \$10,448 to the order of Canfield, and on the morning of December 10th drew its check to his order which said check was received in defendant's division of policy claims at 10:30 A. M. for said sum, and, at the same time, on its records, marked said policy canceled as purchased for its cash surrender value, and also marked said loan as paid and satisfied out of said cash surrender value.

Canfield did not call at the defendant's office or communicate further with it after Pierson's letter of December 9th to him. On the afternoon of December 10th he met with an accident from which he died December 11th, while the check was still in defendant's hands. December 12th defendant mailed the check to him, which check came into the hands of the plaintiff, who is Canfield's executor, and was returned by his attorney in a letter to the defendant. Defendant immediately returned the check to plaintiff's attorney and plaintiff's attorney then wrote the defendant that the check was held subject to its order.

On January 21, 1915, plaintiff furnished due proofs of Canfield's death and demanded payment of the policy, but the defendant duly returned the proofs of death and denied any liability except for the sum of \$10,448, agreed to be paid for the surrender of the policy and thereafter this suit was brought upon the policy.

On December 5, 1914, there was due the annual premium, \$7,277, and a year's loan interest in advance, \$3,972.60, and Canfield had not paid any part thereof. If he defaulted in these payments, the pledge of the policy would be foreclosed in accordance with the terms of the loan agreement, and the loan satisfied in the manner provided in the policy. But the policy allowed a month's grace for premium payment, subject to an

interest charge of 5 per cent and if Canfield had not been satisfied with the defendant's offer he could still within the month of grace pay the premium and loan interest and continue the policy in force.

The policy did not provide for the payment of cash for its surrender. It was only in the event all premiums were paid, the policy in force, and Canfield living December 5, 1919, that the policy gave him the right to surrender it and receive its value in cash. Under the loan provision of the policy, no loan was obtainable theron unless the premiums were duly paid to the anniversary date next succeeding the date when the loan was made; and too, loan interest was payable in advance. If either premium or loan interest was not duly paid, the defendant had a right under the loan agreement to foreclose the pledge of the policy and satisfy the loan out of the value of the policy in the manner provided therein.

The agreement, therefore, by which the company consented to satisfy its loan, cancel the policy and pay \$10,448, was a new and independent contract outside of the terms of the policy and in substitution therefor. It constituted in my opinion a novation and all rights under the policy, as such, came to an end.

In *Bandman vs. Finn*, 185 N. Y. 508, the defendant Finn in May, 1902, became the purchaser of certain premises and executed to one Schmidt, the broker, an agreement by which he agreed to pay \$1,000 on the passing of the title and the additional sum of \$8,600 on the completion of roof on contemplated building on said premises and in the event of a sale of those premises \$8,600 on consummation of said sale. In October, 1903, no building having been erected on the premises and the defendant not having sold the same, Schmidt retained a lawyer, Mr. Levy, to negotiate with the defendant for a satisfaction and surrender. Finally the negotiations terminated in an oral agreement whereby the defendant promised to pay Schmidt the sum of \$2,500 on the Wednesday following and Schmidt agreed to execute to the defendant a release of all his claims and to surrender to him the agreement. The parties met at the time and place appointed and the defendant offered to carry out the contract. Schmidt had not with him the written agreement which was to be surrendered. On the defendant requiring the production of the agreement, Schmidt went away with the ostensible purpose of procuring it. He never returned, but refused to carry out the contract. Thereafter the defendant sold the premises, and after the consummation of that sale, Schmidt having assigned his contract the assignee brought suit for \$8,600. At the conclusion of the evidence plaintiff requested the court to direct a verdict for \$8,600, full amount claimed under the agreement and the defendant for the sum which he had agreed to pay therefor. The Court directed a verdict for the plaintiff for \$2,500. Chief

Judge Cullen said: "The testimony in the case tended to show, we may say conclusively showed, for it was uncontradicted, that on Monday there was effected a complete oral agreement by which, on the Wednesday following, the defendant was to pay Schmidt \$2,500, and Schmidt was to surrender the agreement and release his claim. * * * But the plaintiff insisted that the case was one of accord and satisfaction, and till executed had no binding force and either party was at liberty to withdraw from it. This was the view entertained by the Appellate Division in setting aside the verdict, the learned trial court having directed a verdict on the ground that the new contract entered into between the parties operated as a novation and discharged the liabilities under the old contract. I am of the opinion that the trial court was correct. * * * At the time of the agreement between the parties in November, 1903, there had been no breach of the written contract with the defendant. Under that contract he was obligated to pay only in one or two contingencies, on the completion of the roof of the contemplated building on such premises, or in case of a sale of the same by the defendant. Neither of these contingencies had occurred. Therefore, the situation was that of a creditor holding an unmatured and contingent obligation, agreeing with his debtor for the surrender of the obligation. Even in the case of a claim unmatured, but not contingent, the payment and receipt of a sum less than that specified is a full satisfaction of the larger claims not yet due. (*Brooks vs. White*, 2 Metc. 283; *Bowker vs. Childs*, 3 Allen 434). As is said in the cases it may be much more advantageous to the creditor to obtain the money before it is due, and this is sufficient consideration for receiving a smaller sum. So, also, it has been held than an executory agreement for such a surrender or compromise will be enforced. * * * The plaintiff's assignor having at the time of the second agreement no cause of action against the defendant, I do not see why he could not enter into a valid agreement with the defendant for the transfer and surrender of the latter's obligation to the same extent as he might have done with any third party. * * * The agreement in the present case was not tentative but specific and final. The defendant agreed to pay, and the plaintiff agreed to receive, a specific sum at a specified time and place. Had the defendant defaulted in the performance of his agreement, the plaintiff's assignor could have sued on his promise regardless of the merits of the claim under the original contract. Equally the defendant may hold the plaintiff's assignor to the agreement."

So in the case at bar. The obligation of the company to pay prior to the making of the new agreement was entirely contingent. Canfield had no present right of action and no enforceable claim. The policy contained no provision for its surrender before December 5, 1919. The company was not obliged to pay

Canfield any sum in cash for the surrender of his policy nor could it compel him to accept cash for it and surrender it and Canfield on the other hand was not obliged to surrender his policy for cash nor could he compel the defendant to pay him cash for it except on surrender. Canfield desired to drop the policy and realize what he could on it and therefore he asked the defendant to make him an offer for its purchase and surrender. If the company's cash offer for its surrender was not satisfactory, Canfield still had the option to continue the policy by the payment of the December 5, 1914, premium with interest thereon, and loan interest at any time within the month's period of grace. Not having paid the December 5, 1914, premium and loan interest, Canfield was not then under the policy's terms entitled to any further loan whatever. To be sure the surrender value agreed upon was less than the amount that would have been payable in the event of his death, but death was a contingency which might not happen during the life of the policy; and beside the net benefit available in the event of death was gradually decreasing and would eventually be entirely wiped out.

Canfield's right to discontinue the policy for its cash value at the end of the twenty-year period was contingent on his being then alive and the policy then in full force, and he himself figured that the policy was of no present value to him and that if he carried it to the end of the period he would pay out more than he would receive.

The agreement for the policy's surrender was of benefit and advantage to both parties in that they substituted a present obligation to pay a fixed and definite amount in the place of another amount which was at once unmatured, indefinite and contingent.

It seems to me, therefore, that by the letters which passed between the parties, namely, upon the request of Canfield, an offer made by the company and an acceptance in writing by him, followed immediately by the action of the company in drawing its check and canceling its policy, there was a complete novation and that the executor can only recover upon the new contract voluntarily entered into in his lifetime by his decedent. It follows therefore that the defendant having sent to the plaintiff a check in compliance with the terms of said new contract for the full amount due, which is still in its possession, the judgment appealed from and certain of the findings in the decision should be reversed and new findings made and the complaint dismissed upon the merits with costs to the appellant.

Settle order on notice.

Laughlin, Scott and Page, JJ., concur.

SMITH, J. (Dissenting).

Under the policy in question, after the expiration of fourteen years, Canfield was entitled to a loan of \$89,900; after the ex-

piration of fifteen years he was entitled to a loan of \$97,800. The policy also provides that after the policy has been in force for two full years "if premiums have been duly paid to the anniversary of the insurance next succeeding when the loan is made" the policyholder is entitled to these loans. This policy was dated the 5th day of December, 1899. Canfield died on the 11th day of December, 1914. So that between the 5th day of December, 1914, and the 11th day of December, during which these negotiations were pending, fifteen years had expired. It is clear that in order to obtain a loan of \$97,800 the premium must have been paid for another year. If, however, upon the 4th day of December, 1914, Canfield had applied for a loan of \$89,900 he would have been entitled thereto upon the payment of interest upon that loan for a single day. It may fairly be claimed that the requirement that the premium must be paid to the next succeeding anniversary date would be construed to apply in the case in question to the loan of \$97,800, and that Canfield was entitled upon the 5th or 6th day of December, 1914, to the loan of \$89,900 without the payment of the premium for the year commencing December 5, 1914. This would amount to the surrender value in case the premium was not paid within the thirty days' grace allowed by the statute. It is probably true that from the instrument itself the right to borrow \$89,900 upon December 5th or 6th, 1914, without paying the sixteenth premium due upon the policy might be doubtful, but the defendant itself has put a practical interpretation upon the contract, by which, in my judgment, it is concluded upon this question. In the letter of December 7th the assistant secretary writes to Canfield, "The present cash surrender value of your policy is \$89,900, from which amount the outstanding loan will be deducted." This letter does not purport to grant to Canfield any rights not given in his policy, but to recognize existing rights. If this letter were not forceful as a practical interpretation of the contract it would doubtless bind the company as an estoppel because it is upon this letter that Canfield indicated his choice to accept this surrender value.

If, then, Canfield had the right to this money under the contract as the surrender value of the policy, there was no consideration for his election to accept the same, and until the money was paid and accepted he might withdraw his election. Before the money was paid he died, and the policy I think remained in full force. I therefore vote for affirmance.

UNITED STATES DISTRICT COURT.

W. D. PENNSYLVANIA. No. 1 November Term, 1915.

FREDERICK

v.s.

METROPOLITAN LIFE INS. CO. OF NEW YORK.*

BANKRUPTCY—PROPERTY PASSING TO TRUSTEE—LIFE INSURANCE.

Under Act Pa. April 15, 1868 (P. L. 103), providing that all policies of insurance on the life of any person taken out for the benefit of, or assigned to, a wife or dependent relative, shall be property of the beneficiary, and not subject to the debts of such person, and Bankr. Act July 1, 1898, c. 541, § 6a, 30 Stat. 548 (Comp. St. 1913, § 9590), which provides that the act shall not affect the allowance of exemptions under state laws, insurance on the life of a bankrupt made payable to his wife, although the designation of the beneficiary is revocable by him, is for the benefit of the wife and exempt where no revocation has been made, and no interest therein passes to his trustee under section 70a.

(For other cases, see *Bankruptcy*, Cent. Dig. § 667; Dec. Dig. § 396[3].)

At Law. Action by Elliott Frederick, trustee in bankruptcy of the estate of John E. Schmidt, against the Metropolitan Life Insurance Company of New York. Trial to court, and judgment for defendant.

Alpern & Seder and L. C. Barton, all of Pittsburgh, Pa., for Plaintiff. Jennings & Jennings, of Pittsburgh, Pa., for Defendant.

THOMSON, D. J.

This action is brought by a trustee in bankruptcy to recover the amount of a policy of insurance on the life of a bankrupt. By stipulation filed, the parties waived a trial by jury, submitting the case to the adjudication of the court.

Findings of Fact.

(1) An involuntary petition in bankruptcy was filed on December 19, 1912, against John E. Schmidt, and on January 8, 1913, he was duly adjudged a bankrupt, and Elliott Frederick, the plaintiff herein, was elected trustee of the estate and duly qualified and acted as such trustee.

(2) At the date of the filing of the petition and adjudication, the bankrupt was the owner of a certain policy of life insurance in the Metropolitan Life Insurance Company, issued on July 10, 1909, in the sum of \$5,000, being an ordinary life policy, payable on the death of the insured to Anna M. Schmidt, wife of the insured, beneficiary, with the right of revocation.

(3) On April 4, 1913, John E. Schmidt died, leaving his said

* Decision rendered, July 12, 1916. 235 Fed. Rep. 639.

wife surviving, and due proof of his death was made and delivered to the defendant company and by it accepted.

(4) At the time of the filing of the petition and adjudication, the said policy had a cash surrender value of \$524.04, but the same was not included in the schedules of the bankrupt.

(5) The said policy contained the following provision:—

“Change of beneficiary.—When the right of revocation has been reserved, or in case of the death of any beneficiary under either a revocable or irrevocable designation, the insured, if there be no existing assignment of the policy made as herein provided, may while the policy is in force designate a new beneficiary with or without reserving right of revocation, by filing written notice thereof at the home office of the company accompanied by the policy for suitable indorsement thereon. Such change shall take effect upon the indorsement of the same on the policy by the company. If any beneficiary shall die before the insured, the interest of such beneficiary shall vest in the insured.”

The right of revocation was duly reserved by the terms of the policy.

(6) The insured did not exercise, or attempt to exercise during his lifetime, either before or after the adjudication in bankruptcy, the right of revocation by designating a new beneficiary, in the manner provided by the policy or otherwise, and on April 22, 1913, the defendant company paid to Anna M. Schmidt, the beneficiary named in the policy, the amount of the policy in full.

(7) The petition in bankruptcy was filed on December 12, 1912, the adjudication was had on January 8, 1913, and the bankrupt died on April 4, 1913.

This is an ordinary life policy, taken out by the insured at the age of fifty-four. The policy provides that:—

The company, “in consideration of the annual premium of \$212.41, and with the payment of a like amount on each tenth day of July hereafter, until the death of the insured, promises to pay at the home office of the company in the city of New York, upon receipt at said home office of due proof of the death of John E. Schmidt, of Rochester, county of Beaver, state of Pennsylvania, herein called the insured, five thousand dollars, less any indebtedness hereon to the company and any unpaid portion of premium for the then current policy year upon the surrender of this policy properly received, to Anna M. Schmidt, wife of the insured, beneficiary, with right of revocation.”

It will be noted that thus far there is no condition by which the policy is payable in any case to the insured, to his estate, or to his executors, administrators, or assigns; the payment being unconditionally to the wife, with right of revocation. Then follows the clause above quoted, authorizing a change of beneficiary. The method of effecting this change is therein pointed out, namely:—

"By filing written notice thereof at the home office of the company, accompanied by the policy for suitable indorsement thereon. Such change shall take effect upon the indorsement of the same on the policy by the company."

Then follows the provision:—

"If any beneficiary shall die before the insured, the interest of such beneficiary shall vest in the insured."

There is a later clause that:—

"No assignment of this policy shall be binding upon the company unless it be filed with the company at its home office."

Looking, then, at the policy with its conditions, these propositions may be stated:—

First. The interest of the wife in the policy, during the life of the insured, is not a permanent or vested interest, but inchoate and expectant. *Hopkins vs. Northwestern Life Assur. Co.*, 99 Fed. 199, 40 C. C. A. 1.

Second. This interest or expectancy of the wife can be defeated only by her death before the insured, or by the latter exercising his right to change the beneficiary. If neither of these conditions occur, on the death of the insured the wife's interest becomes vested and absolute.

Third. The conditions under which a change in beneficiary must be effected are for the protection of the insurer, and must be strictly followed unless waived by the company. *Stephenson vs. Stephenson*, 64 Iowa, 534, 21 N. W. 19; *Appeal of Vollman*, 92 Pa. 50.

In this case there is no pretense that any change of beneficiary was made or attempted. On the death of the insured, and proper proofs of death made, the company paid the policy in good faith to the party designated in its contract as sole beneficiary therein, without notice of any character as to any adverse claim thereto. And now, after payment, the trustee in bankruptcy of the insured brings this action to compel the company to pay the policy again. There never was any contract relation between the insurance company and the creditors of the insured. Its contract was to pay the wife \$5,000 on the death of the insured. Two conditions were attached to the contract: That the insured might change the beneficiary in the manner prescribed; and, if the beneficiary died before the insured, the interest of the beneficiary should vest in the insured. Neither of these conditions happened, and therefore, under the terms of the policy, the defendant company never became indebted to the insured, to his estate, to his personal representatives, or to his creditors.

But notwithstanding this, it is claimed that there was a surrender value to the policy; that this surrender value at least was an asset of the bankrupt's estate which passed to his trustee under section 70a of the Bankrupt Act (Act July 1, 1898, c. 541, 30 Stat. 565 [Comp. St. 1913, § 9654]); that the company had

presumptive notice of the bankruptcy of Schmidt; and that under the provisions of said section of the bankruptcy act, inasmuch as the bankrupt did not elect to pay or secure to the trustee the cash surrender value of the policy within thirty days after the same was ascertained, the trustee is entitled to the whole amount of the policy. If this be true, it is certainly a novel legal situation. There has apparently been much conflict of authority in the Federal courts as to the rights of creditors and other claimants to the proceeds of life insurance policies where the insured became bankrupt, arising under sections 6 and 70a of the act of Congress. I will not stop to consider these cases in particular. The conflict is often more apparent than real. This is due to the differing terms of the policies, the widely different facts of the several cases, the difference in the provisions of the acts of the assembly of the several states where the cases have arisen, relating to exemptions, and the fact that many of the decisions were rendered before any authoritative deliverance of the Supreme Court on the subject. But the case of Holden vs. Stratton, 198 U. S. 202, 25 Sup. Ct. 656, 49 L. Ed. 1018, furnishes a rock on which we can stand. That decision has settled definitely and finally these propositions:—

(a) That section 6 of the Bankruptcy Act, which provides as follows:—

"This act shall not affect the allowance to bankrupts of the exemptions which are prescribed by the state laws in force at the time of the filing of the petition in the state wherein they have had their domicile for the six months or the greater portion thereof immediately preceding the filing of the petition"

—is couched in unlimited terms and is accompanied with no qualification whatever.

(b) That it has always been the policy of Congress, both in general legislation and in bankrupt cases, to recognize and give effect to state exemption laws, and that section 6 adopts for the purposes of bankruptcy proceedings the exemptions allowed by the laws of the several states.

(c) That section 70a, and the proviso found therein relating to insurance policies, imposes no limitation whatever upon the terms of section 6. That this section does not deal with exemptions, but solely with the nature and character of the property the title to which passes to the trustee in bankruptcy, and that all exempt property is excluded from its provisions.

This decision sets at rest much of the conflict which theretofore existed in the courts with reference to these sections. For instance, Steel vs. Buel, 104 Fed. 968, 44 C. C. A. 287, held that the proviso to section 70a does not qualify the exemptions accorded by section 6, while the Circuit Court of Appeals for the Ninth Circuit, in *Re Scheld*, 104 Fed. 870, 44 C. C. A. 233, 52 L. R. A. 188, took the opposite position. These are an illustration of the

conflicting views taken by the courts. Holden vs. Stratton has cleared the case of fractions. Section 6 recognizing and intending to give effect to the exemption laws of the state, and section 70a having no application to exempt property, we have only one question remaining: Is the policy in question exempt under the laws of Pennsylvania? If so, that is the end of the plaintiff's case.

There are two acts in Pennsylvania relating to this subject. The Act of April 15, 1868 (P. L. 103), is as follows:—

"All policies of life insurance or annuities upon the life of any person which may hereafter mature, and which have been or shall be taken out for the benefit of, or bona fide assigned to the wife or children or any relative dependent upon such person, shall be vested in such wife or children or other relative, full and clear from all claims of the creditors of such person."

The Act of May 1st, 1876 (P. L. 53), provides:—

"A policy of insurance issued by any company incorporated under this act, on the life of any person expressed to be for the benefit of any married woman, whether procured by herself, her husband, or any other person, shall inure to her separate use and benefit, and that of her children, independently of her husband or his creditors, or the person effecting the same, or * * * with intent to defraud his creditors, an amount equal to the premium so paid with interest thereon shall inure to their benefit."

Looking at the Act of 1868, is there anything in this case, is there a single fact, which should compel the court to hold that this policy was not taken out for the benefit of the wife? If it was taken out for her benefit, there is no foundation for plaintiff's claim. The best evidence that it was so taken out by the decedent is the fact that she was made the sole beneficiary in the policy, and that he died without defeating or attempting to defeat his wife's interest in the policy. But it is assumed that the whole case is changed by the reservation of the right of the assured to change the beneficiary. This clause has the legal effect of changing the interest of the beneficiary from a vested to an inchoate or expectant interest. But I cannot see why, from that fact, the court should find the policy was not taken out for the benefit of the wife. An insurer knows that time may bring a very material change in conditions. The marital relation itself is unfortunately subject to many vicissitudes, such as death, divorce, or separation. In the lapse of a few years the dependant may become independent, and those now strong may demand our aid and assistance. To reserve the right to change one's mind, if circumstances demand it, is in harmony with the whole course of human action. It is only the part of wisdom to take into consideration the ever-changing conditions of men. Persons frequently revoke their wills, add codicils, and change devisees, to meet conditions as they arise; and it is only natural

that a husband who takes out a life policy for the benefit of his wife should reserve to himself the power to change the beneficiary if unexpected conditions should arise which make it necessary or advisable. We should remember that exemptions in favor of the wife, children, or other dependents, are favorites of the law. The Supreme Court, in Holden vs. Stratton, quotes approvingly from the opinion of Circuit Judge Caldwell, as follows:—

"From the organization of the Federal courts under the Judiciary Act of 1789, the law has been that creditors suing in these courts could not subject to execution property of their debtor exempt to him by the law of the state." (Citing Lamaster vs. Keeler, 123 U. S. 376, 8 Sup. Ct. 197, 31 L. Ed. 238, and other cases.) "The same rule has obtained under the bankrupt acts, which have sometimes increased the exemption, notably so under the act of 1867, * * * but have never lessened or diminished them. An intention on the part of Congress to violate or abolish this wise and uniform rule observed from the creation of our Federal system should be made to appear by clear and unmistakable language. It will not be presumed from a doubtful or ambiguous provision fairly susceptible of any other construction."

In support of the proposition that the right to change the beneficiary passes the property in the policy to the trustee, counsel have cited numerous cases. In *Re Herr* (D. C.) 182 Fed. 716, the policy was payable to the bankrupt, and only contingently to the wife. In *Re Dolan* (D. C.) 182 Fed. 949, the policy was a twenty-year endowment, payable to the insured, or, in the event of her death during the endowment period, to her executors, administrators, or assigns. It was held by the District Court that the policy was property which could have been transferred prior to the filing of a petition under section 70a, and therefore passed to the trustee. The Pennsylvania exemption acts do not appear to have been involved in the decision and were not referred to. In *Re Jamison Bros. Co.* (D. C.) 222 Fed. 92, Judge Dickinson, while laying down certain principles for the guidance of the referee, did not undertake to pass upon the effect of the Pennsylvania statutes of exemptions on the case before him.

The Supreme Court of Pennsylvania has recognized and enforced the act of 1868 in numerous cases, where there was a conflict between the beneficiary and creditors of the insured. *Anderson's Estate*, 85 Pa. 202; *McCutcheon's Appeal*, 99 Pa. 133; *Schad's Appeal*, 88 Pa. 111; and *Sebring vs. Brickley*, 7 Pa. Super. Ct. 198.

As this was a life policy, payable under its terms only in the event of death, there was no property in the insured which could have been levied upon or sold under judicial process. The insured could not have willed the proceeds to another, as at the instant of

his death it would have passed to the beneficiary. *Vollman's Appeal*, 92 Pa. 50.

The plaintiff, in view of Holden vs. Stratton, must base his right to recover on the assumption that the policy is not exempt; in other words, that it was not taken out for the benefit of the wife. And then, proceeding on that assumption, he claims under the proviso to section 70a that the trustee was first entitled to the cash surrender value, and afterwards, by reason of the failure of the assured to pay or secure this amount, to the whole amount of the policy.

Turning to the proviso, we find:—

"That when any bankrupt shall have any insurance policy which has a cash surrender value payable to himself, his estate, or personal representatives, he may, within thirty days after the cash surrender value has been ascertained and stated to the trustee by the company issuing the same, pay or secure to the trustee the sum so ascertained and stated, and continue to hold, own, and carry such policy free from the claims of the creditors participating in the distribution of his estate under the bankruptcy proceedings, otherwise the policy shall pass to the trustee as assets."

I fail to find in the policy any provision for a cash surrender value payable to the insured, his estate, or personal representatives; but, if the policy can be so construed, how can the policy itself, which is payable to the wife, ever become assets of her husband's estate, and pass to his trustee, unless the beneficiary is changed, and no one has power to change the beneficiary except the insured himself. Under the decisions in *Burlingham vs. Crouse*, 228 U. S. 459, 33 Sup. Ct. 564, 57 L. Ed. 920, 46 L. R. A. (N. S.) 148, *Everett vs. Judson*, 228 U. S. 474, 33 Sup. Ct. 568, 57 L. Ed. 927, 46 L. R. A. (N. S.) 154, and *Andrews vs. Partridge*, 228 U. S. 479, 33 Sup. Ct. 570, 57 L. Ed. 929, respectively, the interest of the estate could not possibly extend beyond the surrender value of the policy. But, as I view the policy, it was taken out for the benefit of the wife, is therefore exempt under the Pennsylvania statute, was an inchoate or expectant interest, which existed during the life of the insured, and ripened at his death into an absolute vested interest, entitling her to the whole of the policy. The conclusion herein reached is in harmony with the opinion of the Circuit Court of Appeals of the Second Circuit, in *Burlingham vs. Crouse*, 181 Fed. 479, 104 C. C. A. 227, and *In re Hammel & Company*, 221 Fed. 56, 137 C. C. A. 80. Also *In re Booss* (D. C.) 154 Fed. 494.

Judgment is therefore entered in favor of the defendant.

SUPREME COURT OF ARKANSAS.

MUTUAL LIFE INS. CO.

vs.

HENLEY. (No. 180.)*

INSURANCE—LIFE INSURANCE—PREMIUMS—PAYMENT.

A life policy issued by a mutual insurance company providing for an annual premium declared that the company would accept premiums semi-annually or quarterly, provided the change was made on any anniversary of the date of the policy. It was insured's custom to apply dividends to payment of the policy. When the annual premium became due, insured's dividend was sufficient in amount to have paid the premium in advance for one quarter. The premium was not paid by insured until a few days after the expiration of the month of grace for payment of premiums. The company retained the premium payment and dividend until insured's death, having notified her that she would be reinstated upon passing another medical examination. *Held*, that as it is the duty of the officers of a mutual insurance company to give just and reasonable protection to the rights of policy-holders, and as the dividend in the possession of the company when the premium became due was sufficient to have paid a quarter's premium, and the remainder of the yearly premium was received within that quarter, the policy cannot be deemed as having lapsed, though insured did not specifically direct the dividend to be used in paying a quarter's premium.

(For other cases, see Insurance, Cent. Dig. § 920; Dec. Dig. § 360[3].)

Appeal from Circuit Court, Monroe County; Thos. C. Trimble, Judge.

Action by J. D. Henley, guardian for J. D. Henley, Jr., against the Mutual Life Insurance Company. From a judgment for plaintiff, defendant appeals. Affirmed.

J. D. Henley, guardian for J. D. Henley, Jr., sued the Mutual Life Insurance Company of New York to recover \$3,000, the amount of an insurance policy issued by it to Addie L. Henley, payable to J. D. Henley, Jr., her minor child. The policy was issued on the 8th day of March, 1909, and Addie L. Henley died on the 17th day of March, 1915. The premium was \$46.98, payable in advance on December 8th of each year. The husband of the insured paid the premium every year and always remitted to the company the amount of the premium, less the dividend. The defendant was a mutual life insurance company, and the dividend on the policy earned in 1914 was, on December 8th, \$13.02. The company gave the insured notice of the date of the payment of the annual premium. The policy contained a clause which gave the insured thirty days of grace within which to pay the annual premium. On January 4, 1915, the defendant wrote a letter addressed to Mrs. Addie Henley at her home at Brinkley, Ark., in which it notified her that the thirty days of grace allowed within which to make payment under her policy would expire on January 8, 1915. The letter continued as follows:—

* Decision rendered, Oct. 9, 1916. 188 S. W. Rep. 829.

"The amount due on that date is as follows:—

Premium	\$46.98
Less dividend	13.02
	<hr/>
	\$33.96
Interest on total for thirty days at 5 per cent15
	<hr/>
Total	\$34.11

"Kindly send check to cover."

On the 18th day of January, 1915, the husband of the insured mailed a check for the \$33.96 to the insurance company. The insurance company collected the check and deposited it to what they called a suspense account. That is to say, they did not apply the check in payment of the annual premium, but wrote to the insured that her policy could be reinstated upon her submitting to a medical examination and sending the proper health certificate. In the meantime they retained the check for the premium, and also the dividend. Other letters were sent to her and her husband urging her to submit to an examination and send in a health certificate for the purpose of reinstating her policy which the agent of the company claimed had been forfeited because the premium had not been paid prior to the 8th day of January, 1915. During the pendency of the negotiations Mrs. Henley was in the state of Texas on a visit, and died on March 17, 1915. The insurance company was notified of the death of Mrs. Henley. It then returned to her husband the amount of the check which he had sent to them on January 18th in payment of the annual premium on her policy. About a week later the husband received a check for \$13.02 for the dividend. The insurance policy also contained the following:—

"Payment of Premiums: The company will accept payment of premiums at other times than as stated above, as follows: \$24.42 $\frac{1}{2}$ -annually on each 8th day of December and June, or \$12.45 $\frac{3}{4}$ -annually on each 8th day of December, March, June, and September, provided such change is made on any anniversary of the date of this policy."

One of the agents of the insurance company testified that it had been the custom of Mrs. Henley, since she had taken out the policy sued on, to apply her dividends on the payment of the annual premiums. He also testified that Mrs. Henley never asked to change the date of the payment of her premium. The case was tried before the court sitting as a jury. The court found the issues in favor of the plaintiff, and a judgment was entered accordingly. The defendant has appealed.

Rose, Hemingway, Cantrell, Loughborough & Miles, of Little Rock, Lee & Moore, of Clarendon, and Frederick L. Allen, of New York City, for Appellant.

G. Otis Bogle and C. F. Greenlee, both of Brinkley, for Appellee.

HART, J. (after stating the facts as above).

The principles of law governing cases of this character is stated in the case of the Union Central Life Insurance Co. vs. Caldwell, 68 Ark. 505, 58 S. W. 355, as follows:—

"The proof showed that the assured had the right to have the dividends applied otherwise. In the absence of any stipulation in the policy, and of any directions otherwise by the assured as to the application of dividends which have been declared, it is the duty of a mutual company to apply such dividends to the payment of interest on loans made on the policy, when by so doing a forfeiture of all rights and benefits under the policy will

be prevented. This is the rule in the case of premiums to keep the policy in force from year to year, and, of course, would be for the payment of interest on an ordinary loan, which prevents a sale of the policy."

The court said that the doctrine had its origin in that fundamental principle of justice which will compel one who has funds in his hands belonging to another, which may be used, to use such funds, if at all, for the benefit, and not to the injury, of the owner; for his consent to the one, and dissent to the other, will be presumed. Forfeitures are not favored either at law or in equity, and so far as is reasonable contracts are to be construed so as to avoid a forfeiture. Policyholders in a mutual insurance company are members of the corporation, and are entitled to have the officers and agents give just and reasonable protection to their rights. Insurance contracts are written on printed forms carefully prepared by experts of the company, and it is not necessary to cite authorities to sustain the proposition that forfeitures are only enforced when it appears that this is the plain meaning of the contract.

In the instant case the premiums were payable annually on the 8th day of December, and the policy contained a provision allowing thirty days of grace within which to pay the premium. The policy also contained a provision that the premium might be paid semi-annually or quarterly. Quarterly on the 8th of December, March, June, and September, in the sum of \$12.45 for each quarter. The company had in its hands a dividend to the credit of the assured in the sum of \$13.02. This was more than sufficient to pay the premium for the first quarter. But it is urged on the part of the insurance company that the assured had not elected to pay the premium in quarterly instalments, and that in the absence of such election the company was not required to apply the dividends to the payment of the premium because there was not sufficient amount on hand to pay the whole annual premium. We do not agree with counsel for the insurance company. In the application of the rule announced in the case above cited, we think the consent of the assured to the appropriation of the dividend to the payment of the first quarterly instalment may be presumed. The assured contracted with the insurance company to pay her a stated sum at her death. She became a member of a mutual insurance company, the duty of whose officers, as we have already seen, is to give just and reasonable protection to the rights of the members. Hence it is not to be supposed that a member and policyholder would object to the company applying the dividend in its hands to the payment of the quarterly instalment of his premium, and thereby forfeit his policy, and thus defeat the end sought to be accomplished by him in making the contract of insurance. The amount of dividends in the hands of the company belonging to the assured was \$13.02. On the 18th

of January, 1915, the husband of the assured sent his check to the company for \$33.96, the balance of the annual premium. It had been the custom of the company to apply the dividend towards the payment of the annual premium.

When all the facts are considered in the light of the principles of law above stated, we think the court was right in holding there was no forfeiture of the policy, and its judgment must be affirmed.

COURT OF APPEALS OF KENTUCKY.

MERIDIAN LIFE INS. CO.

vs.

MILAM.*

1. INSURANCE—LIFE INSURANCE—DATE OF POLICY.

Where a life insurance policy by its terms provided that the period of contestability shall be calculated "from the date" of the policy, the year of contestability will be calculated from that date, and not from the date of its delivery to insured.

(For other cases, see Insurance, Cent. Dig. §§ 362-371; Dec. Dig. § 175.)

Appeal from Circuit Court, Logan County.

Action by Mary C. Milam against the Meridian Life Insurance Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Browder & Browder, of Russellville, for Appellant.
S. R. Crewdson, of Russellville, for Appellee.

MILLER, C. J.

On June 8, 1914, the appellant, the Meridian Life Insurance Company, of Indianapolis, Ind., issued its policy contract to James W. Milam, whereby, in consideration of a promise of \$49.18 then paid, and the agreement of Milam to pay a like sum annually on June 8th for eight years thereafter, and after the expiration of the nine years to pay an annual premium of \$98.36, it insured the life of James W. Milam for \$2,500. Mary C. Milam, the wife of James W. Milam, was named as a beneficiary in the policy. James W. Milam died on June 8, 1915; and, proofs of death having been made, and the company having declined to pay the policy, Mary C. Milam filed this action on September 2, 1915, to recover the amount named in the policy.

* Decision rendered, Nov. 2, 1916. 188 S. W. Rep. 879.

There is no dispute about the facts in this case; the controverted questions relate solely to the law of the case. The policy contains this provision:—

"This policy shall not be in force until the first premium has been paid thereon, and the policy duly delivered during the lifetime and good health of the insured."

It also contained this further provision:—

"In case of death after one year from the date hereof this policy shall be incontestable, except for nonpayment of premiums, provided the covenant for military and naval service in time of war, as provided in the application, shall have been complied with."

By his application, which is made a part of the contract of insurance, Milam agreed:—

"That death by my own hands, or occasioned by my own act, whether voluntary or involuntary, whether I be sane or insane, or whether death be intended or anticipated as the result of such act, or in consequence the actual or attempted violation of the law, within one year from the date of any policy issued hereunder, shall invalidate the insurance and forfeit the payment of the company."

By way of defense the answer alleged: (1) That, while the policy bears date June 8, 1914, it was not actually delivered until June 13, 1914; (2) that Milam, the insured, committed suicide on June 8, 1915, which was within one year from date of the policy, and that, by the terms of the application above set forth, all liability under the policy was thereby anulled; and (3) that the policy was procured by fraud in this respect, that at the time of and before the date of the policy, Milam was affected with gallstones and that he fraudulently concealed that fact, and represented that he had never suffered from that disease.

The circuit court sustained a general demurrer to the answer; and, the defendant having declined to further plead, judgment went for the plaintiff for the amount of the policy. The company appeals.

The governing point upon which the whole case hinges is this: Did Milam die after one year from the date of the policy? If he did, the policy, by its terms, is incontestable, and the judgment of the circuit court was right.

[1] 1. In order to avoid the effect of the one year clause after which the policy could not be contested, the company alleged, and now contends, that while the policy bears date June 8, 1914, yet, as a matter of fact, the policy was not delivered, or the first premium paid, until June 13, 1914; and that, Milam having died on June 8, 1915, he dies within a year "from the date" of the policy.

We see no merit in this contention. While it is true that insurance companies frequently, and we believe usually, do not

deliver a policy upon the day of its date, nevertheless all the provisions of the policy as to payments of future premiums, its maturity if it runs for a term, and similar provisions, are calculated from the day of its date. Of course, the insured can contract for a policy to be dated on any date after the date of his applications; but, as a matter of routine business, policies are usually dated either according to the date of the application, or of its execution, and are subsequently delivered without any question being made upon that subject. But the rights of the parties to the contract are determined by the date, and all future premiums are to be paid accordingly.

If Milam had died on June 12, 1915, without having paid his second premium due on June 8, 1915, could it be said that his policy had not lapsed for failure to pay the premium when due, according to the terms of the contract? Under such a state of case would the company concede that his policy was in force on June 12, 1915, and that Milam had until that day to pay the premium? We think not. Furthermore, the policy, by its terms, provides that the period of contestability shall be calculated "from the date" of the policy, not from the date of its delivery. So by the very terms of the policy the one-year period of contestability began to run on June 8, 1914.

2. The company further insists, however, that if June 8th is to control as the date of the policy, then Milam died within one year from that date, and the policy is contestable under the provisions avoiding it for suicide and fraud, and that the demurrer to the answer relying upon those defenses was improperly sustained.

So, speaking concretely, the case resolves itself to this: Was June 8, 1915, the day of Milam's death, within or after one year from June 8, 1914?

[2, 3] The rule in regard to the computation of time is well settled, and is this: When the computation is to be made from the act done, the day on which the act is done must be included; but, when the computation is to be made from the day itself, and not from the act done, then the day on which the act is done must be excluded from the computation. *Handley vs. Cunningham*, 12 Bush, 401; *Mooar vs. Covington City National Bank*, 80 Ky. 307; *Board of Councilmen of Frankfort vs. Farmers' Bank of Kentucky*, 105 Ky. 811, 49 S. W. 811, 20 Ky. Law Rep. 1635; *Erwin vs. Benton*, 120 Ky. 548, 87 S. W. 291, 27 Ky. Law Rep. 909, 9 Ann. Cas. 264; *Geneva Cooperage Co. vs. Brown*, 124 Ky. 16, 98 S. W. 279, 30 Ky. Law Rep. 272, 124 Ann. St. Rep. 388; *Newton vs. Ogden*, 126 Ky. 101, 102 S. W. 865, 31 Ky. Law Rep. 549; *Louisville Ry. Co. vs. Wellington*, 137 Ky. 728, 126 S. W. 370, 128 S. W. 1077; and the cases there cited; and *Lowry vs. Stotts*, 138 Ky. 251, 127 S. W. 789. The

working of the rule may be illustrated by reciting the facts and the conclusions reached in two of the cases cited.

In Handley vs. Cunningham, *supra*, the question was whether the act of 1871 reducing the legal rate of interest from 10 per cent to 8 per cent was in force on September 1st of that year, the date of the notes in question. The statute provided that it should "take effect and be in force from and after the first day of September, 1871." The court applied the rule that, when the time is counted from a day, the day was not to be included, and held that the act of 1871 was not in force on September 1, 1871. *East Tennessee Tel. Co. vs. Board of Councilmen, etc.*, 142 Ky. 408, 134 S. W. 475, is also a good illustration of this application of the rule. But in *Board of Councilmen of Frankfort vs. Farmers' Bank of Kentucky*, *supra*, the statute required that an appeal should not be granted except within two years next after the right of appeal has accrued. In that case the judgment was rendered on January 21, 1896; the appeal was granted on January 21, 1898. It was held that the appeal had not been granted within two years next after the judgment had been rendered, because the two years expired on January 20, 1898, the day before the appeal was granted.

In the case at bar, therefore, the year of contestability must be computed from the dating of the policy, which was an act done on June 8, 1914. Manifestly, therefore, June 8, 1914, must be included in the computation, and the first year of the policy expired on June 7, 1915. Otherwise the year would have contained 366 days, instead of 365 days. But by the terms of the policy the insured was not required to pay the second premium until the first day of the second year, and, as there are no parts of days to be considered, he had all of June 8, 1915, in which to pay the second premium; and consequently the policy remained in force throughout that day. Milam having died on June 8, 1915, while the policy was in force, and not contestable, it became a charge against the company. The fact that he had not paid the premium for the second year when he died cannot affect the appellee's rights under the policy, since Milam was not then in default in the payment of any premium. Indeed, the company does not claim that the policy lapsed for failure to pay the second premium.

It follows, therefore, that since Milam did not die within one year from the date of the policy, it was contestable upon either ground relied upon, and that the circuit court properly sustained the demurrer to the answer.

Judgment affirmed.

GERMAN-AMERICAN TRUST CO. ET AL. *vs.* TEN
WINKEL ET AL. (No. 8920.)*
(Supreme Court of Colorado.)

1. INSURANCE—CHANGE OF BENEFICIARY—WILL.

Where an insured holding two valid contracts of life insurance called certificates of membership, whereby on his death the insurer agreed to pay his surviving wife one-quarter and the remainder to a trust company "in trust for his children," a direction in his will that the sum due or to become due to his estate from the insurer should be applied as far as necessary on payment of an incumbrance on his house, the balance to revert to his residuary estate, without any attempt in the manner and form prescribed to change the beneficiaries, did not constitute a change of the beneficiaries named in the certificates, nor a legal or equitable transfer of the fund arising therefrom.
(For other cases, see Insurance, Cent. Dig. § 1469; Dec. Dig. § 587.)

2. INSURANCE—PROCEEDS OF POLICY—PERSONS ENTITLED.

And upon the death of the insured, one-fourth of the proceeds of the certificates of insurance vested in his surviving wife, and the remaining three-fourths in equal parts in his three children, and, where the wife died intestate and before her actual possession of her share of the funds, her administrator might sue for and collect it.
(For other cases, see Insurance, Cent. Dig. §§ 1472-1474; Dec. Dig. § 589.)

En Banc. Error to District Court, City and County of Denver; Granby Hillyer, Judge.

Suit by Fred H. Ten Winkel, as administrator of the estate of Aleta Hall, deceased, and others against the Bankers' Life Company and Paul Ray Hall, and another, in which the German-American Trust Company, as administrator to collect the estate of B. R. Hall, deceased, intervened. Judgment for plaintiffs, and the intervener and defendant Paul Ray Hall bring error, and apply for a supersedeas. Application denied, and judgment affirmed.

Charles F. Miller, of Denver, for Plaintiffs in Error.

Tolles & Cobbey, of Denver, for Defendant in Error Fred H. Ten Winkel, as administrator, etc., and P. M. Kistler, of Colorado Springs, for Defendants in Error George M. Hall and William C. Hall.

* Decision rendered, Oct. 2, 1916. 160 Pac. Rep. 188.

SEABACK vs. METROPOLITAN LIFE INS. CO.

(No. 10355.)*

(Supreme Court of Illinois.)

1. INSURANCE—VOID POLICY—RECOVERY OF PREMIUMS.

Where a policy is void from the beginning, and there is no fraud on the part of the insured, he may recover the premiums paid by him.
(For other cases, see Insurance, Cent. Dig. § 459; Dec. Dig. § 198[5].)

2. INSURANCE—FORFEITURE — W A I V E R — FAILURE TO RETURN PREMIUMS.

The mere failure of an insurance company to return premiums on a policy void from the beginning, for breach of condition, is not a waiver of its right to forfeit the policy.
(For other cases, see Insurance, Cent. Dig. §§ 534-536; Dec. Dig. § 247.)

3. INSURANCE—ACTIONS ON POLICY—BURDEN OF PROOF—WAIVER OF FORFEITURE.

The burden of proving a waiver or an estoppel on the part of an insurance company to forfeit a policy is on the beneficiary.
(For other cases, see Insurance, Cent. Dig. § 1653; Dec. Dig. § 646[3].)

4. INSURANCE—FORFEITURE OF POLICY—WAIVER.

To constitute a waiver of forfeiture of a policy, it must appear that the company expressed an intention to relinquish the defense, or that its negotiations or transactions after knowledge of the forfeiture recognized the continued validity of the policy.
(For other cases, see Insurance, Cent. Dig. §§ 943-946; Dec. Dig. § 371.)

5. INSURANCE—DEFENSES—B R E A C H O F CONDITION — RETURN OF PREMIUMS.

The return of premiums paid on an insurance policy void from the beginning is not a condition precedent to the right of the company to defend an action on the policy.
(For other cases, see Insurance, Cent. Dig. § 1520; Dec. Dig. § 612[1].)

6. INSURANCE—VOID POLICY—RIGHT TO PREMIUMS.

The right to recover premiums paid on an insurance policy void from the beginning is the right of the insured or her personal representative, not of the beneficiary.
(For other cases, see Insurance, Cent. Dig. §§ 465-467; Dec. Dig. § 198[6].)

Appeal from Appellate Court, Second District, on Appeal from Circuit Court, Bureau County; Joe A. Davis, Judge.

Action by Minnie Seaback, for whom was substituted after her death Charles Sulski, against the Metropolitan Life Insurance Company. Judgment for plaintiff was reversed by the Appellate Court, and the plaintiff appeals. Judgment of the Appellate Court affirmed.

Butters & Clark, of Ottawa, for Appellant.
Duncan & O'Connor, of Ottawa, for Appellee.

* Decision rendered, Oct. 24, 1916. 113 N. E. Rep. 862.

GIBSON ET AL. vs. IOWA LEGION OF HONOR.

(No. 29922.)*

(Supreme Court of Iowa.)

10. INSURANCE—PLEADING—CHANGE IN CONSTITUTION.

In an action on an insurance certificate, an amended petition, stating that defendant claimed, and claims, "that it had the right and authority to make said changes and so amend said constitution; that said changes were by written resolution made and adopted by said Grand Lodge at its regular meeting"—is not such an admission of legal adoption of the amendments as to discharge defendant's burden of showing compliance with various provisions of the constitution relating to amendments.

(For other cases, see Insurance, Cent. Dig. §§ 1999, 2000; Dec. Dig. § 817[1].)

11. INSURANCE—BENEFIT INSURANCE—CONSTITUTION—NOTICE OF CHANGE.

Defendant's allegation that a publication containing official notice to its members, published on a date named, was mailed to plaintiff by depositing it in the postoffice, properly addressed to him at his last known address, with postage prepaid, and that he received the same in due course of the mails, was not proven by testimony of its secretary that he saw the name of plaintiff's intestate put on the mailing list, although he could not swear positively that it was mailed, and which failed to show what postoffice the paper was addressed to.

(For other cases, see Insurance, Cent. Dig. § 2006; Dec. Dig. § 819[1].)

12. INSURANCE—BENEFIT INSURANCE—CHANGE IN BY-LAWS—ESTOPPEL.

By seeking to excuse a nonpayment of an increased assessment on certificate of plaintiff's intestate on the ground that the change of the Constitution operated as a renunciation of the contract, plaintiffs are not estopped to assert that the changes were not lawfully made, or that their intestate did not have notice of the change, since the change is legal only if lawfully made and the required notice given; and, if the beneficiary learns there has been an unlawful change, he may assert that it is in fact illegal, and, as an additional reason, why it is illegal.

(For other cases, see Insurance, Cent. Dig. § 1867; Dec. Dig. § 724[3].)

14.—INSURANCE—BENEFIT INSURANCE—BY-LAWS—NOTICE OF CHANGE.

Although the members of a mutual insurance society are bound to take notice of and be governed by its laws, whether adopted prior or subsequent to the contract, it is competent for the parties to contract to stipulate what alone shall be legal notice of a change.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[1].)

15. INSURANCE—BENEFIT INSURANCE—BY-LAWS—NOTICE OF CHANGE.

Where a change in defendant's constitution which raised the assessment of plaintiff's intestate and scaled his certificate was not legally adopted, and legal notice thereof was not given, the intestate was under no obligation to make or tender payment at the rate existing before the

* Decision rendered, Oct. 17, 1916. 159 N. W. Rep. 639.

change, since on renunciation there arose a right to elect whether to hold the insurer for damages, or to wait until the policy became payable according to its tenor, and surviving the beneficiary.

(For other cases, see Insurance, Cent. Dig. § 1906; Dec. Dig. § 754.)

16. INSURANCE—MUTUAL BENEFIT INSURANCE—CERTIFICATE—FORFEITURE.

Where the insurer refuses one payment, claiming his policy is forfeited, there is no forfeiture for failure to tender payment of the premium thereafter.

(For other cases, see Insurance, Cent. Dig. § 1906; Dec. Dig. § 754.)

17. INSURANCE—BENEFIT ASSOCIATIONS—EXPULSION OF MEMBER.

Where a benefit association attempts to expel a member and the proceedings are void for irregularity, and there is a subsequent refusal to pay dues, the failure of insured to continue to tender dues cannot prejudice his rights.

(For other cases, see Insurance, Cent. Dig. § 1906; Dec. Dig. § 754.)

18. INSURANCE—BENEFIT INSURANCE—ASSESSMENTS—TENDER.

Where an assessment is irregular and void, insured is not required to make tender or to obtain data by which to figure out correctly what would be the proper amount to pay or tender, or take chances on his tender being sufficient, if rejected, to preserve his rights.

(For other cases, see Insurance, Cent. Dig. § 1906; Dec. Dig. § 754.)

19. INSURANCE—BENEFIT INSURANCE—WAIVER.

Where there was no notice to insured either of a reduction of the certificate or an increase of the assessment, there could be no waiver of the right to urge that the change was invalid, since a waiver is a voluntary relinquishment of a known right, made when in possession of all material facts affecting it, and the notice which will base a waiver or estoppel should not be inferential.

(For other cases, see Insurance, Cent. Dig. § 1867; Dec. Dig. § 724[3].)

20. INSURANCE—BENEFIT INSURANCE—I L L E G A L ASSESSMENTS—RATIFICATION.

Payment of an illegal assessment, demanded under a change in the constitution, will not ratify the change, so that changes will not excuse a later nonpayment, unless there is evidence that the former payments were made with knowledge of the payor's rights.

(For other cases, see Insurance, Cent. Dig. § 1867; Dec. Dig. § 724[3].)

21. INSURANCE—BENEFIT INSURANCE—WAIVER.

A waiver, created by payment of illegal assessments, cannot estop assured from refusing to continue to pay the illegal exaction.

(For other cases, see Insurance, Cent. Dig. § 1885; Dec. Dig. § 738.)

23. INSURANCE—BENEFIT INSURANCE—BURDEN OF PROOF.

Where defendant pleaded a waiver and estoppel because illegal assessments were paid with full knowledge of the change, it has the burden of proving that there was such payment, and that it constituted a waiver and estoppel.

(For other cases, see Insurance, Cent. Dig. § 2003; Dec. Dig. § 818[1].)

24.—INSURANCE—ASSESSMENTS—CHANGE—ESTOPPEL.

Defendant's allegation of estoppel to deny the legality of an assessment because three assessments had been paid with full knowledge of the change was not sustained by proof which failed to show that such payments were made at all or that the alleged payments induced any change of position on the part of the defendant, or that plaintiffs' intestate had knowledge of his rights.

(For other cases, see Insurance, Cent. Dig. § 1867; Dec. Dig. § 724[3].)

26. INSURANCE—BENEFIT INSURANCE—PROOF OF LOSS—NECESSITY.

Where the defendant before suit denied liability on a claim of suspension, it cannot defend on the ground of delay in making proof of loss and giving notice.

(For other cases, see Insurance, Cent. Dig. § 1965; Dec. Dig. § 789[2].)

28.—INSURANCE—BENEFIT INSURANCE—CONTRACT—LIMITATIONS.

Where there was no evidence offered in support of defendant's allegations that the sum named in the certificate was conditional, plaintiff is entitled to recover judgment for the full amount of the certificate; the allegations as to limitations being matters of defense.

(For other cases, see Insurance, Cent. Dig. § 2002; Dec. Dig. § 817[4].)

Appeal from District Court, Clinton County; A. J. House, Judge.
 Action at law to recover the sum of \$2,000, upon a certificate of membership by defendant to Charles V. Cook. Verdict for \$1,813 directed for plaintiffs. Defendant appeals. Affirmed.

A. L. Schuyler, of Clinton, and Jamison, Smith & Hann, of Cedar Rapids, for Appellant.

J. M. Fort, of Clinton, for Appellees.

**GRIMES ET AL vs. CENTRAL LIFE INS. CO.***

(Court of Appeals of Kentucky.)

7. INSURANCE—REGULATION OF INSURANCE COMPANIES—SUIT FOR DISSOLUTION—STATUTORY REMEDY.

Prior to 1893, the insurance business of the state was carried on without state supervision, resulting in numerous losses to stockholders and policyholders from mismanagement or fraud of promoters or officers and frequent and expensive litigation against solvent companies by irresponsible persons. The act of April 5, 1893, which now composes part of Ky. St. c. 32, art. 4, contained detailed and comprehensive provisions regulating insurance corporations. Section 628 of that article authorizes suit by a majority of the stockholders of any insurance company for its dissolution, but there is no provision for a similar suit by less than a majority or by any number of policyholders. Section 752 requires the Insurance Commissioner appointed

* Decision rendered, Nov. 1, 1916. 188 S. W. Rep. 901.

under the act to investigate each domestic insurance company at least once in four years, and to make such investigation whenever he may be requested to do so by five or more policyholders, stockholders, or creditors. Section 753 provides that if the Commissioner is of the opinion that such company is insolvent or has exceeded its powers or disobeyed the law, he may suspend its license and apply to the court for an injunction to restrain it from continuing business in the state, and the court in such suit may appoint receivers to settle the company's affairs. *Held*, that the remedy thus provided furnished adequate protection to the stockholders and policyholders, and that the act, when construed in the light of the evils it was intended to remedy, made such remedy exclusive of the common-law right of any policyholder to sue for the dissolution of an insolvent insurance company, and of any stockholder to bring such suit when mismanagement of the corporation threatens it with insolvency, or has already rendered it insolvent.

(For other cases, see Insurance, Cent. Dig. § 57; Dec. Dig. § 49.)

Turner, J., dissenting.

Appeal from Circuit Court, Fayette County.

Suit by Charles M. Grimes and others against the Central Life Insurance Company. Judgment for the defendant, and plaintiffs appeal. Affirmed.

Maury Kemper and Forman & Forman, all of Lexington, for Appellants.

Jos. S. Botts and Geo. C. Webb, both of Lexington, and H. V. McChesney, of Frankfort, for Appellee.



SOVEREIGN CAMP, WOODMEN OF THE WORLD, *vs.*
BURTON.*

(Court of Appeals of Kentucky.)

INSURANCE—LIFE INSURANCE—DEATH WHILE VIOLATING LAW—QUESTION FOR JURY.

In an action on the life insurance certificate of a fraternal insurance society exempted from liability if the insured should die in consequence of a duel or of the violation or attempted violation of the laws of the state, the United States, or any province or nation, whether or not at the time insured was shot and killed he was engaged in a violation or attempted violation of the law of Arkansas, *held* for the jury.

(For other cases, see Insurance, Cent. Dig. § 2009; Dec. Dig. § 825[3].)

Appeal from Circuit Court; McCracken County.

Action by Mary Burton against the Sovereign Camp, Woodmen of the World. From a judgment for plaintiff, defendant appeals. Judgment affirmed.

Coleman & Wells, of Murray, for Appellant.
Eaton & Boyd, of Paducah, for Appellee.

* Decision rendered, Oct. 5, 1916. 188 S. W. Rep. 402.

MAHEU vs. L'UNION LAFAYETTE.*

(Supreme Judicial Court of Maine.)

INSURANCE—LIABILITY FOR BENEFITS—VALIDITY OF CHANGE IN BY-LAWS.

A mutual benefit society cannot, by amending its by-laws during the illness of a member, reduce the amount it has already become liable to pay to him by reason of an existing illness; the amendment being wholly void as respects liabilities already incurred.

(For other cases, see Insurance, Cent. Dig. § 1855; Dec. Dig. § 719[4].)

Agreed statement from Supreme Judicial Court, Kennebec County, at Law.

Action by Frank J. Maheu against L'Union Lafayette. Agreed statement from Supreme Judicial Court. Judgment for plaintiff.

Argued before Savage, C. J., and Cornish, King, Haley, Hanson, and Philbrook, JJ.

F. W. Clair, of Waterville, for Plaintiff.

P. A. Smith, of Waterville, for Defendant.

* Decision rendered, Oct. 19, 1916. 98 Atl. Rep. 821.

ABRAMOVITZ ET AL. vs. NATIONAL COUNCIL OF KNIGHTS AND LADIES OF SECURITY.

(No. 20077[19].)*

(Supreme Court of Minnesota.)

1. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—ACTIONS—CONDITIONS PRECEDENT.

A membership certificate issued by defendant, a fraternal beneficiary society, provided that: "No action can or shall be maintained on this certificate until after proofs of death and claimant's rights to benefits as provided in the laws of the order have been filed with the National Secretary," etc. *Held*, that this provision made it a condition precedent to the right of action that the beneficiaries named in the certificate present to defendant the proofs specified.

(For other cases, see Insurance, Cent. Dig. § 1990; Dec. Dig. § 807.)

2. INSURANCE—FRATERNAL BENEFICIARY INSURANCE—PROOFS OF DEATH—WAIVER.

Defendant did not waive such proofs, either by pleading inconsistent defenses or by denial of liability in the answer. The defenses were not inconsistent, for they might all be true. The denial of liability in

* Decision rendered, Oct. 20, 1916. 159 N. W. Rep. 624. Syllabus by the Court.

order to effect a waiver of proofs of loss must have preceded the institution of the suit. There is no such denial pleaded.
(For other cases, see Insurance, Cent. Dig. § 1965; Dec. Dig. § 789[2].)

Appeal from District Court, Ramsey County; James C. Michael, Judge.

Action by Aneta Abramovitz and others against the National Council of the Knights and Ladies of Security. Judgment for plaintiffs, and defendant appeals. Reversed, and new trial ordered.

William G. White, of St. Paul, for Appellant.
A. J. Hertz and James E. Markham, both of St. Paul, for Respondents.

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SIMMONS *vs.* MODERN WOODMEN OF AMERICA.
(No. 11692.)*

(Kansas City Court of Appeals. Missouri.)

1. INSURANCE—MUTUAL BENEFIT INSURANCE—CONSTRUCTION OF CERTIFICATE—INITIATION OF PERIOD LIMITED FOR SUIT.

Where, under the terms of a death benefit certificate, the beneficiary had no right to sue until the insurer rejected her demand, she could not sue until advised by the insurer of its rejection, and, until so advised, the period limited by the certificate within which she must bring suit did not begin to run.

(For other cases, see Insurance, Cent. Dig. § 1993; Dec. Dig. § 812.)

2. INSURANCE—MUTUAL BENEFIT INSURANCE—FINAL NOTICE OF REJECTION OF CLAIM—SUFFICIENCY OF EVIDENCE.

In an action on a death benefit certificate, the court, as a trier of fact, was entitled to infer that final unequivocal notice of rejection of her demand was not given plaintiff before a date within the limitation period of the certificate, from proof that the insurer's board of directors formally decided to reject plaintiff's claim December 16, 1911, and notified her, but thereafter wrote a letter, stating that the matter had been referred to their general attorney, with whom she could hold further communication.

(For other cases, see Insurance, Cent. Dig. § 2006; Dec. Dig. § 819[1].)

3. INSURANCE—FRATERNAL BENEFIT INSURANCE—WAIVER OF CONTRACTUAL EXEMPTION FROM LIABILITY.

Where the wife of a member of a fraternal benefit association, when her husband became a brakeman, a hazardous employment excluded from the policy unless the association were notified and application made to extend the terms of the policy to cover the occupation, etc., went to the local agent of the association and told him the facts, being assured that everything was all right, and he would find out if there was

* Decision rendered, June 12, 1916. 188 S. W. Rep. 932.

anything she should do with the policy, engaging to let her know if there was, and the officers of the association, with knowledge of the facts, for two years thereafter collected and retained dues, knowing that the member, relying on the promises of the agent, believed that his certificate covered the risks of his hazardous employment, the association itself, and not its agent, waived the contractual exemption from liability for the hazardous risk.

(For other cases, see Insurance, Cent. Dig. §§ 1909-1913, 1915, 1916; Dec. Dig. § 755[3].)

Appeal from Circuit Court, Adair County; C. D. Stewart, Judge.
"Not to be officially published."

Action by Emily Amelia Simmons against the Modern Woodmen of America. From a judgment for plaintiff, defendant appeals. Judgment affirmed.

Truman Plantz, of Warsaw, Ill., Bailey & Hart, of Brookfield, and F. M. McDavid, of Springfield, for Appellant.

Campbell & Ellison and Weatherby & Frank, all of Kirksville, for Respondent.



SUPREME LODGE, KNIGHTS OF PYTHIAS, *vs.*
RUTZLER ET AL. (No. 36/178.)*
(Court of Chancery of New Jersey.)

INSURANCE—PAYMENT OF BENEFITS—DEATH OF BENEFICIARY.

Where a fraternal insurance policy was payable to one of the daughters of insured, as trustee for a minor daughter, and there was an oral understanding that, in case anything happened to the minor daughter, it was to revert to her sisters, and the minor daughter survived insured, but died before the benefit was paid, her administratrix, and not the trustee or the sister, is entitled to the proceeds of the policy.

(For other cases, see Insurance, Cent. Dig. § 1975; Dec. Dig. § 796.)

Bill by Supreme Lodge, Knights of Pythias, against Lillian M. Rutzler, trustee, and others, to restrain the prosecution of a suit at law. On bill, answer, replication, and proofs. Injunction granted.

McDermott & Enright, of Jersey City, for Complainant.
Frank G. Turner, of Jersey City, for Defendants.

* Decision rendered, Sept. 20, 1916. 98 Atl. Rep. 836.

**DUSENBURY vs. GENERAL GRANT COUNCIL, No. 128,
JUNIOR ORDER UNITED AMERICAN MECHANICS
OF STATE OF NEW YORK.***

(Supreme Court of New York, Appellate Term, Second Department.)

1. INSURANCE—MUTUAL BENEFIT—ACTION ON CERTIFICATE—PARTIES DEFENDANT.

Where defendant council was incorporated under the laws of the state and under a charter granted to it by a benefit association, and where insured was elected a beneficiary member of the defendant and enrolled on the books of the association as such, and the certificate, which was issued not by the defendant council but by the association, provided that, on compliance with the laws of the council and its good standing in the association and the surrender of the certificate, the association would pay the treasurer of the council a certain amount which sum his council had agreed to pay as a death benefit to his designated beneficiary, and where the certificate bore the corporate seal of the association and was signed by its proper officers and countersigned by the recording secretary of the council, a beneficiary's action was properly brought against the council, without impleading the association.

(For other cases, see Insurance, Cent. Dig. § 1994; Dec. Dig. § 813.)

3. INSURANCE—MUTUAL BENEFIT—BENEFICIARIES—RIGHT OF ACTION.

Under Laws 1911, c. 198, amending the Insurance Law (Consol. Laws, c. 28) § 231, par. 2, and providing that death benefits may be payable to a relative to fourth degree of consanguinity or dependent, and the by-laws of a council defining the term "legal beneficiary" as used in its certificates to mean widow, children, or other blood relatives of the member, the wife of the member's uncle and not a dependent had no right of action on the certificate.

(For other cases, see Insurance, Cent. Dig. §§ 1932, 1937, 1938; Dec. Dig. § 769.)

Appeal from Municipal Court, Borough of Brooklyn, Third District. Action by Mary S. Dusenbury against General Grant Council, No. 128, Junior Order United American Mechanics of the State of New York. From a judgment of the Municipal Court of the City of New York, Borough of Brooklyn, Third District, rendered July 17, 1916, in favor of the plaintiff after a trial by the court without a jury for \$541.94 damages and costs, and from the denial of its motion to compel the plaintiff to serve a reply to the answer, defendant appeals. Reversed, and complaint dismissed.

Argued September term, 1916, before Benedict, Jaycox, and Clark, JJ.

Thomas O'Rourke Gallagher, of New York City, for Appellant.
David Siegelman, of Brooklyn, for Respondent.

* Decision rendered, September, 1916. 161 N. Y. Supp. 103.

**REED *vs.* NATIONAL ORDER OF DAUGHTERS OF
ISABELLA ET AL.***

(New York Supreme Court, Special Term, Oneida County.)

**3. INSURANCE—BENEFICIAL ASSOCIATIONS—MEMBERSHIP—
EXPULSION—GROUNDS.**

Where the laws and rules of a national fraternal order provide that any officer of a subordinate court absenting herself from three regular meetings in succession unless excused by a majority of her court, shall forfeit her office, the act of the grand regent of a local court, in acting as presiding officer when the court declares vacant the office of a trustee who has been absent for six regular business meetings in succession and refuses to present an excuse when given an opportunity, and elects a new trustee, is no justification for expulsion of the grand regent, even if the contention be sustained that the only remedy of a local court under the rule mentioned is to report the case to the national body and have it declare the office vacant.

(For other cases, see Insurance, Cent. Dig. § 1835; Dec. Dig. § 694[2].)

**4. INSURANCE—BENEFICIAL ASSOCIATIONS—MEMBERSHIP—
EXPULSION—GROUNDS.**

The presiding officer of a local court of nearly 400 members, of a fraternal order, cannot be said to have power to control the action of the court in directing its treasurer to refuse to comply with the request of the state regent to send the books, warrants, and vouchers to a distant part of the state, and such action does not justify her expulsion from membership by the national body.

(For other cases, see Insurance, Cent. Dig. § 1835; Dec. Dig. § 694[2].)

**5. INSURANCE—BENEFICIAL ASSOCIATIONS—MEMBERSHIP—
EXPULSION—PROCEDURE.**

A member of a fraternal order, before expulsion, is entitled to a fair trial before an impartial tribunal, and if the method is not regulated by the laws of the association it should be analogous to ordinary judicial proceedings, so far, at least, as to permit substantial justice.

(For other cases, see Insurance, Cent. Dig. § 1835; Dec. Dig. § 694[2].)

**6. INSURANCE—BENEFICIAL ASSOCIATIONS—MEMBERSHIP—
EXPULSION—PROCEDURE.**

Those who allege irregularity in a proceeding to expel a member of a fraternal order must be held to strict proof, for no presumption will be indulged to support a forfeiture.

(For other cases, see Insurance, Cent. Dig. § 1835; Dec. Dig. § 694[2].)

**7. INSURANCE—BENEFICIAL ASSOCIATION—REMOVAL OF
MEMBER—RE COURSE TO COURTS—SCOPE OF INQUIRY.**

While the court, on an application to compel the reinstatement of a member of a fraternal order, cannot consider the weight of the evidence, yet, if the determination of the national body of the order is unsupported by any substantial evidence, it is subject to review and correction.

(For other cases, see Insurance, Cent. Dig. §§ 1834, 1835; Dec. Dig. § 694[3].)

* Decision rendered, June, 1916. 160 N. Y. Supp. 907.

8. INSURANCE—BENEFICIAL ASSOCIATIONS—MEMBERSHIP—EXPULSION—VOTE REQUIRED.

Under General Corporation Law (Laws 1909 c. 28 [Consol. Laws c. 23]) § 34, providing that the act of a majority of a quorum present at a meeting of a board of directors shall be the act of the board, where there is nothing in the laws of a fraternal order designating the number of votes required to expel a member, the vote for expulsion should be by a majority of the directors present, not merely a majority of those voting; there being nothing to the contrary in the Membership Corporations Law (Consol. Laws, c. 35).

(For other cases, see Insurance, Cent. Dig. § 1835; Dec. Dig. § 694[2].)

Application by Isabel W. G. Reed for mandamus to the National Order of the Daughters of Isabella and others. Granted.

Warnick J. Kernan and Daniel E. Meegan both of Utica, for Petitioner.

Russell H. Brennan, of Utica, for Defendants O'Donnell, Henry, and Wankel.

P. H. Fitzgerald, of Utica, for National Order of Daughters of Isabella and others.



**CONTINENTAL BENEFICIAL ASS'N vs. ARBOGAST
ET AL. (No. 7636.)***
(Supreme Court of Oklahoma.)

INSURANCE—MUTUAL BENEFIT INSURANCE—AMOUNT OF LIABILITY.

A mutual benefit association issued a fraternal certificate of insurance upon the life of A. The original company was succeeded by a second company, which, in turn, was succeeded by a third, and it in turn by a fourth. Each succeeding company issued an assumption certificate, accepting the preceding certificate with modifications and conditions. The assumption certificate of the third company, accepting the assured as a member, was conditioned upon his payment of dues regularly, and was expressly made subject to the constitution and by-laws of the company as it then existed or might thereafter be amended. The constitution at the time provided that all members holding certificates of membership providing for death benefits, written at a lower rate than the table of rates provided by the constitution of the order, might continue to pay the present rate, but such certificate should be charged with the difference between the rate paid by the member and the rate provided in the constitution for a period equal to the expectancy of life, based upon the American Experience Table of Mortality, which should be deducted from death benefits that might become due thereunder. The defendant, the fourth company, in its assumption certificate accepted A. as a member, conditioned that in no case should he be entitled to greater benefits than he would have been

* Decision rendered, July 25, 1916. Rehearing denied, Oct. 17, 1916. 160 Pac. Rep. 87. Syllabus by the Court.

if he had remained in the third and preceding company. *Held*, that in a suit to recover upon the certificate, the defendant the fourth company may deduct from the amount of the certificate the difference between the rate paid by the member and the rate named in the constitution of the third and preceding company, for a period equal to the expectancy of life of a person of that age, based upon the American Experience Table of Mortality.

(For other cases, see Insurance, Cent. Dig. §§ 1961, 1962; Dec. Dig. § 791[1].)

Commissioners' Opinion, Division No. 4. Error from District Court, Cleveland County; F. B. Swank, Judge.

Action by Mary M. Arbogast, for herself and as guardian, and others against the Continental Beneficial Association. Judgment for plaintiffs, and defendant brings error. Reversed and rendered.

Ben F. Williams and John E. Luttrell, both of Norman, for Plaintiff in Error.

W. L. Eagleton and Thomas W. Mayfield, both of Norman, for defendants in Error.



EQUITABLE LIFE ASSUR. SOC. OF THE UNITED STATES ET AL. vs. WEIGHTMAN. (No. 7787).*

(Supreme Court of Oklahoma.)

1. INSURANCE—RIGHT TO PROCEEDS—WRONGFUL ACT OF BENEFICIARY.

A beneficiary in a policy of life insurance, who murders the assured, is thereby barred from collecting the insurance money.

(For other cases, see Insurance, Cent. Dig. § 1150; Dec. Dig. § 448.)

2. INSURANCE—ASSIGNMENT—RIGHTS OF ASSIGNEE.

The insurance policy being a nonnegotiable instrument, the assignee of such a beneficiary has no better claim upon the insurance money than his assignor.

(For other cases, see Insurance, Cent. Dig. §§ 1455-1458, 1483, 1485; Dec. Dig. § 594.)

3. INSURANCE—RIGHT TO PROCEEDS—JOINT POLICIES.

Provisions of a life insurance policy upon the lives of two persons, providing for the payment of the insurance fund to the survivor of the first decedent, examined, and *held*, that the policy in question, so far as the insurance fund payable on such contingency is involved, is a several policy upon the life of each of the assured, and that the interest of the assured persons in such expectancy is not a joint tenancy, by reason of which one takes by the right of survivorship upon the death of the other, but that the survivor takes, if at all, under the contract.

(For other cases, see Insurance, Cent. Dig. §§ 1461, 1464, 1466, 1468; Dec. Dig. § 585[1].)

* Decision rendered, Oct. 17, 1916. 160 Pac. Rep. 629. Syllabus by the Court.

4. INSURANCE—RIGHT TO PROCEEDS—ESTATE OF INSURED.

Where no alternative beneficiary is designated in a contract of life insurance, and the designated beneficiary becomes barred from taking the benefits of the policy by reason of the fact that she has murdered the assured, in the absence of a statute which provides an alternative beneficiary, by operation of law a trust arises in favor of the estate of the assured, by virtue of which the representative of the assured is entitled to recover the insurance fund.

(For other cases, see Insurance, Cent. Dig. §§ 1461, 1464, 1466, 1468; Dec. Dig. § 585[1].)

Commissioners' Opinion, Division No. 3. Error from District Court, Cleveland County; F. B. Swank, Judge.

Action by Ben F. Williams against the Equitable Life Assurance Society of the United States, and J. T. Weightman, administrator of the estate of Thomas J. Gentry, intervenes. Judgment for intervenor, and plaintiff and defendant bring error. Affirmed.

Alexander & Green, of New York City, Stephen C. Treadwell, of Oklahoma City, and Locke & Locke, of Dallas, Tex., for Plaintiff in Error Equitable Life Assur. Soc.

Lydick & Eggerman, of Shawnee, for Plaintiff in Error Williams.

Kittie C. Sturdevant, of Shawnee, and Dorset Carter, of Oklahoma City, for Defendant in Error.



FRIEND vs. SOUTHERN STATES LIFE INS. CO.

(No. 4672.)*

(Supreme Court of Oklahoma.)

1. INSURANCE—ACTION ON POLICY—PLEADING—EXHIBITS.

Where an action is brought on a policy of life insurance, and a copy of the policy is attached to the petition and made a part thereof, such copy should be considered as a part of the petition when construing the allegations thereof on demurrer.

(For other cases, see Insurance, Cent. Dig. §§ 1588, 1589; Dec. Dig. § 631.)

2. INSURANCE—CONTRACT—NATURE.

A policy of life insurance, without any qualifying provisions, is not a contract of insurance for a single year, with a privilege of renewal from year to year by paying the annual premiums. It is an indivisible and continuous contract of insurance for life, subject, when so stipulated, to discontinuance and forfeiture for nonpayment of any installment of premium. Such premium installments are not intended as the consideration for the respective years for which they are paid, but each installment is part consideration of the entire insurance for life.

(For other cases, see Insurance, Cent. Dig. § 891; Dec. Dig. § 349[1].)

3. INSURANCE—PREMIUMS—EFFECT OF DEFAULT.

The consequence of a default in payment of one annual premium, due under an indivisible and continuous contract of insurance, is deter-

* Decision rendered, Oct. 10, 1916. 160 Pac. Rep. 457. Syllabus by the Court.

mined by common-law principles, where the contract does not otherwise provide.

(For other cases, see Insurance, Cent. Dig. § 891; Dec. Dig. § 349[1].)

4. INSURANCE—PREMIUMS—EFFECT OF DEFAULT.

Ordinarily the payment of an annual premium on a policy of life insurance, after the policy has become effective by payment of the first year's premium, is not a condition precedent to the continuance of the policy, but, on the contrary, is a condition subsequent only, the nonperformance of which may incur a forfeiture of the policy, or may not, according to the circumstances.

(For other cases, see Insurance, Cent. Dig. § 891; Dec. Dig. § 349[1].)

5. INSURANCE—PREMIUMS—EFFECT OF DEFAULT.

A clause in a policy of life insurance which provides only that "this policy is incontestable after one year from date of the breach of any of the provisions thereof, except failure to pay premiums as required," and which further provides that upon payment of the policy the company may deduct any sum or sums due the company, does not forfeit the policy for failure to pay the annual premium when due; but the insurance continues in force, subject to the right of the company to terminate it, if after due notice the insured shall fail to pay the premium in arrears with interest, and the further right to retain out of any settlement arising under the policy the unpaid premium and interest thereon.

(For other cases, see Insurance, Cent. Dig. § 904; Dec. Dig. § 310[2].)

6. INSURANCE—CONTRACT—CONSTRUCTION.

Forfeitures are looked upon by the courts with ill favor, and will be enforced only when the strict letter of the contract requires it. On the question of forfeiture of a life insurance policy, which is so framed as to be fairly open to construction, the view should be adopted, if possible, which will sustain rather than forfeit the contract of insurance.

(For other cases, see Insurance, Cent. Dig. § 295; Dec. Dig. § 146[3].)

Error from District Court, Oklahoma County; George W. Clark, Judge.

Action by Julia A. Friend against the Southern States Life Insurance Company. From a judgment sustaining a demurrer to the petition and dismissing the cause of action, plaintiff brings error. Reversed and remanded with instructions to overrule the demurrer and set aside the order of dismissal with leave to defendant to answer.

Everest, Smith & Campbell and Hunt C. Hill, all of Oklahoma City, for Plaintiff in Error.

Wilson & Tomerlin and E. E. Buckholts, all of Oklahoma City, for Defendant in Error.

WEST END TRUST CO. *vs.* FIDELITY MUT. LIFE
INS. CO.*

(Supreme Court of Pennsylvania.)

INSURANCE—MUTUAL BENEFIT INSURANCE—PREMIUMS—
RIGHT TO RECOVER.

Where insured did not promptly notify a mutual company of his election to rescind the contract, and, subsequent assessments being unpaid, insured's interest as a member was distributed among the members, dues and premiums already paid cannot be recovered on the theory that insured had properly rescinded his contract.

(For other cases, see Insurance, Cent. Dig. § 1888; Dec. Dig. § 743.)

Appeal from Court of Common Pleas, Philadelphia County.
Action by the West End Trust Company, executor of Henry A. Borell, deceased, against the Fidelity Mutual Life Insurance Company. From a judgment for defendant, plaintiff appeals. Affirmed.

Argued before Brown, C. J., and Mestrezat, Stewart, Frazer, and Walling, JJ.

Rudolph M. Schick, of Philadelphia, for Appellant.
Ira Jewell Williams, Marshall S. Winpenny, and George H. Wilson, all of Philadelphia, for Appellee.

* Decision rendered, May 15, 1916. 98 Atl. Rep. 768.



JONES *vs.* NORTH CAROLINA MUTUAL & PROVIDENT
ASS'N. (No. 9516.)*

(Supreme Court of South Carolina.)

1. INSURANCE—LIFE INSURANCE—RIGHTS OF BENEFICIARY.
A beneficiary named in a life insurance policy has a vested interest, which can only be taken away by his consent or by virtue of the exercise of the right vested in the policy itself.

(For other cases, see Insurance, Cent. Dig. § 1470; Dec. Dig. § 586.)

2. INSURANCE—LIFE INSURANCE—CHANGE OF BENEFICIARY
—CONSENT.

Under an ordinary life insurance policy issued in consideration of the application therefor, and subject only to the conditions and agreements named therein, and containing nothing conferring upon the insured the right to change the beneficiary named in the policy without her consent, neither the insured nor the insurer nor the two together had the right to change the beneficiary without her consent.

(For other cases, see Insurance, Cent. Dig. § 1469; Dec. Dig. § 587.)

* Decision rendered, Sept. 21, 1916. 90 S. E. Rep. 30.

3. INSURANCE—LIFE INSURANCE—CHANGE OF BENEFICIARY—EVIDENCE.

In an action involving the right of the insured to change the beneficiary named in the policy without her consent, the provisions of the insurer's constitution and by-laws not brought to the insurer's knowledge could not be resorted to in order to furnish authority for a change without the consent of the beneficiary.

(For other cases, see *Insurance, Cent. Dig.* § 1673; *Dec. Dig.* § 651[1].)

Appeal from Common Pleas Circuit Court of Abbeville County; Fred L. Willcox, Special Judge.

Action by Hattie Jones against the North Carolina Mutual and Provident Association. Judgment for plaintiff, and defendant appeals. Affirmed.

The decree of the Circuit Court was as follows:—

"This case comes before me upon appeal from a judgment in favor of plaintiff in the court of Magistrate J. S. Hammond.

"It appears from the pleadings, the evidence, and the exception, and also upon the argument before me, that there is really only one question involved.

"If the party insured, J. R. Davis, on account of whose death while he was holding a policy in the defendant association the suit was brought to recover the amount specified in the policy, had a right to require the company to make the loss payable to a new beneficiary, without the consent of Hattie Jones, the beneficiary named in the policy, then the judgment of the magistrate might be reversed. If on the other hand no such right existed, without the consent of Hattie Jones, the judgment of the magistrate should be affirmed and the appeal dismissed.

"[1-3] The policy seems to be an ordinary life insurance policy, as distinguished from a certificate of membership in a mutual protective association. It is issued in consideration of the application thereof and of the payment of premiums specified therein and is subject only to the conditions and agreements named therein. There is nothing whatever in the policy itself conferring the right upon the assured to change the beneficiary, without her consent. The South Carolina authorities cited by counsel for the defendant seem to establish clearly legal proposition that a beneficiary named in a life insurance policy has a vested interest which can only be taken away by her consent or by virtue of the exercise of the right vested in the policy itself.

"I am not impressed with the position taken by defendant to the effect that the provisions of its constitution and by-laws can be resorted to in order to furnish authority for a change, without the consent of the beneficiary. My impression is that the correct principle applicable in such matters is stated in the case of *Relief Fire Insurance Co. vs. Shaw*, 94 U. S. 574, 24 L. Ed. 291.

"My conclusion is that neither the insured nor the defendants, nor the two together had at any time after the issuing of the policy involved in this suit the right to change the beneficiary, and thereby destroy the vested interest of Hattie Jones in the policy, without her consent.

"It is therefore ordered that the judgment of the magistrate be affirmed, and the appeal of the defendant dismissed."

J. M. Nickles, of Abbeville, for Appellant.

Wm. N. Graydon, of Abbeville, for Respondent.

SIMMONS vs. SOVEREIGN CAMP, WOODMEN OF THE WORLD.*

(Supreme Court of Tennessee.)

INSURANCE—FRATERNAL BENEFIT INSURANCE—FORFEITURE OF CERTIFICATE.

Under Acts 1905, c. 480, providing that the constitution and laws of a fraternal association may provide that no subordinate body, officer, or member may waive any provision of its laws and constitution and the same shall be binding on the association, and every member, where the constitution and laws of the defendant fraternal benefit association provided required notice of a change of occupation within thirty days the member should be suspended and his certificate null and void, and that the clerk of camp shall not by acts, representations, or waivers, or by vote of his camp, have authority not delegated to him, and that such official has no authority to waive conditions of beneficiary certificates or provisions of the constitution or laws, where deceased changed his occupation from farmer to locomotive fireman without notice until six months after the lapse of the thirty-day period, defendant was not bound by any act of estoppel or waiver of the clerk of the local camp in receiving the notice, without knowledge or acquiescence on the part of its sovereign officials.

(For other cases, see Insurance, Cent. Dig. § 1908; Dec. Dig. § 755[2].)

Appeal from Chancery Court, Morgan County; A. H. Roberts, Chancellor.

Suit by C. Simmons against the Sovereign Camp, Woodmen of the World. Judgment for plaintiff, and defendant appeals. Reversed, and bill of complaint dismissed.

Cornick, Frantz, McConnell & Seymour, of Knoxville, and Cassell & Harris, of Harriman, for Appellant.

J. M. Davis, of Wartburg, and W. Y. Boswell, of Oakdale, for Appellee.

* Decision rendered, Oct. 26, 1916. 188 S. W. Rep. 941.



**COLE vs. KNIGHTS OF MACCABEES OF THE WORLD.
(No. 979.)***

(Court of Civil Appeals of Texas. Amarillo.)

1. INSURANCE—MUTUAL BENEFIT INSURANCE—ACTION ON POLICY—PLEADING—ISSUES.

In an action on a policy of benefit insurance, where plaintiff beneficiary alleged specifically the duty of defendant to notify deceased of suspension for nonpayment of dues it was not necessary for defendant to allege the fact of notice before introducing evidence that all delin-

* Decision rendered, May 10, 1916. On motion for rehearing, Oct. 11, 1916. 188 S. W. Rep. 699.

quent members were duly notified by written notice in regular form by mail.

(For other cases, see Insurance, Cent. Dig. § 1998; Dec. Dig. § 815[4].)

5. INSURANCE—MUTUAL BENEFIT INSURANCE—BY-LAWS.

In an action on a policy of fraternal benefit insurance, where a by-law clearly provided that a member failing to pay his monthly rate within the month shall be suspended without notice, and the evidence is sufficient to sustain the judgment based upon it, obscurity in other by-laws pleaded would have no bearing upon the issue of the failure of assured to pay his monthly rate.

(For other cases, see Insurance, Cent. Dig. §§ 1895, 1896, 1903; Dec. Dig. § 750.)

On Motion for Rehearing.

6. INSURANCE—MUTUAL BENEFIT INSURANCE—NOTICE OF FORFEITURE—BY-LAWS.

Under by-laws of a mutual benefit insurance association, providing for suspension, without notice, of assured from all rights for failure to pay monthly rate within the month on first day due, and for notice of such suspension to an official, who shall report it to the next meeting, no affirmative action or notice to assured of forfeiture on part of the association was necessary to forfeit the certificate, but the failure of the member to make the required payment ipso facto worked a forfeiture.

(For other cases, see Insurance, Cent. Dig. § 1917; Dec. Dig. § 756[1].)

Error from District Court, Dallas County; J. C. Roberts, Judge.

Action by Mrs. Lizzie Cole against the Knights of the Maccabees of the World. Judgment for defendant and plaintiff brings error. Affirmed.

H. W. Peck, of Dallas, for Plaintiff in Error.

Cross & Rogers, of Waco, for Defendant in Error.



GRAND LODGE OF BROTHERHOOD OF RAILROAD TRAINMEN *vs.* KENNEDY ET AL. (No. 1007.)*

(Court of Civil Appeals of Texas. Amarillo.)

1. INSURANCE—MUTUAL BENEFIT INSURANCE—REINSTATEMENT—QUESTION FOR JURY.

Evidence held to warrant submission to jury of issue whether member of fraternal benefit association signed regular form for reinstatement and delivered it to the local lodge so as to make binding his reinstatement and render the association liable upon his death.

(For other cases, see Insurance, Cent. Dig. § 2009; Dec. Dig. § 825[1].)

2. INSURANCE—MUTUAL BENEFIT INSURANCE—RIGHT OF MEMBERS.

The right of reinstatement after expulsion is just as much a right, in a contractual sense, as the right to pay dues to the officers of a local

* Decision rendered, June 7, 1916. Rehearing denied, Oct. 4, 1916. 188 S. W. Rep. 447.

lodge, with the expectation of a remittance to a grand lodge to keep alive existing privileges, and an expelled member, who abides with the law of the order and signs a proper application for readmission, is entitled to reinstatement.

(For other cases, see Insurance, Cent. Dig. §§ 1920, 1921; Dec. Dig. § 759.)

Appeal from District Court, Grayson County; W. M. Peck, Judge.

Action by Mrs. Nanty Kennedy and others against the Grand Lodge of Brotherhood of Railroad Trainmen. Judgment for plaintiffs, and defendant appeals. Affirmed.

Wood, Jones & Hassell, of Sherman, for Appellant.
Sturgeon, Blackburn & Sturgeon, of Paris, for Appellees.

FIRE, TORNADO, ETC.

SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FIRST DEPARTMENT.

LLOYD

vs

NORTH BRITISH & MERCANTILE INS. CO. OF LONDON AND
 EDINBURGH.*

1. INSURANCE—UNCONDITIONAL AND SOLE OWNERSHIP.

Unconditional and sole ownership, which a fire policy requires insured to have, relates to the quality of his title, and not to the question of liens or incumbrances.

(For other cases, see Insurance, Cent. Dig. §§ 613, 614; Dec. Dig. § 282[6].)

2. INSURANCE—UNCONDITIONAL AND SOLE OWNERSHIP.

Insured, as required by fire policy, had the unconditional and sole ownership, notwithstanding the provision of his existing contract to build a boat for H. that, should its completion be prevented, all materials bought for it should belong to H., and H. should own an interest in insured's boathouse, amounting to the sum paid by him on the contract above the cost of materials bought for the boat.

(For other cases, see Insurance, Cent. Dig. §§ 613, 614; Dec. Dig. § 282[6].)

3. INSURANCE—INCUMBRANCE BY CHATTEL MORTGAGE.

An equitable lien or interest, under contract by insured that, if he fails to complete a boat, H. shall own an interest in the insured property to the amount paid on the contract, is not an incumbrance by chattel mortgage, within the prohibition of the fire policy.

(For other cases, see Insurance, Cent. Dig. §§ 613, 614; Dec. Dig. § 282[6].)

4. INSURANCE—PROOFS OF LOSS—WAIVER.

Proof of loss under a fire policy is waived, insurer writing to insured of information given it of a contract made by insured, erroneously claimed by insurer to void the policy, and stating, "Assuming, * * * in the absence of information to the contrary, that the facts are as stated to us, we are taking no steps looking to an adjustment," the effect of this being a disclaimer of liability; insured being unable to deny the making of the contract.

(For other cases, see Insurance, Cent. Dig. §§ 1391, 1392; Dec. Dig. § 559[1].)

Appeal from Trial Term, New York County.

Action by Harry W. Lloyd against the North British & Mercantile Insurance Company of London & Edinburgh. From a judgment on a verdict for plaintiff, and from an order denying its motion for new trial, defendant appeals. Affirmed.

* Decision rendered, Nov. 3, 1916. 161 N. Y. Supp. 271.

Argued before Clarke, P. J., and Laughlin, Scott, Smith, and Page, JJ.

Leo Levy, of New York City (Alex Davis, of New York City, on the brief), for Appellant.

William G. Philippeau, of New York City, for Respondent.

LAUGHLIN, J.

This is an action on an insurance policy to recover for a fire loss. The policy was issued by the defendant to the plaintiff on the 6th day of February, 1913, and by its provisions the defendant insured the plaintiff against loss by fire during the ensuing year on a one-story frame building occupied as a boat-building shop, at Yonkers, N. Y., and on the tools and machinery therein, and on a houseboat under construction therein. The property was destroyed by fire on the 27th day of September, 1913. The policy is not printed in full in the record, and from the extracts thereof printed it does not appear what the interest of the plaintiff in the property was stated to be in the policy. It was, however, provided that, if his interest was not truly stated, the policy should be void, and that it should be void if his interest "be other than unconditional and sole ownership, or if the subject of insurance be personal property and be or become incumbered by a chattel mortgage." It was further provided therein that the plaintiff should give immediate notice in writing to the company of any loss by fire, and that within sixty days after the fire he should render a statement to the company, signed and sworn to by him, stating, among other things, "the interest of the insured and of all others in the property, the cash value of each item thereof and the amount of loss thereon," and "all incumbrances thereon." On the 3d day of October, 1913, the plaintiff delivered or transmitted to the company an unverified statement or schedule, which was received in evidence as Exhibit 5, and which contains numerous items of property under the heading "Specifications of 40' Cabin Launch," and other items under the heading "Boat Shop," but no valuations, and *numerous other items, with valuation of each*, under the heading "Inventory of Machinery and Tools of Harry W. Lloyd," the total valuation of these items aggregating \$173.70; but said statement contained no representation with respect to the ownership of the property, other than that quoted with respect to the machinery and tools, and no reference to a fire or loss.

The evidence is conflicting with respect to the channel through which this statement was transmitted to the company; but it was stamped, "Received Oct. 3, 1913, N. B. & M. Ins. Co.," and was produced by defendant on the trial. The houseboat was being built by the plaintiff for A. J. Hambrecht, pursuant to an agreement in writing, signed by the plaintiff and delivered to Hambrecht, under date of November 13, 1912, as follows:—

"I hereby agree to build for A. J. Hambrecht, of 278 Haw-

thorne avenue, Yonkers, N. Y., one houseboat, to be forty feet long and about twelve feet beam, for the sum of one dollar and other compensation. Should anything happen preventing the construction of said boat, or prevent completion of said boat when under construction, all materials bought for said boat shall belong to A. J. Hambrecht, and said Mr. Hambrecht shall own an interest in the boat shop located north of Yonkers Corinthian Yacht Club (80 ft.) amounting to the sum of all moneys paid to me above the actual cost of all materials bought for said boat. I acknowledge the receipt of one hundred dollars in two payments of fifty dollars to date."

The construction of the houseboat was commenced prior to the issuance of the policy, and it was nearly completed at the time of the fire, but was still in the possession of the plaintiff in his boat-building shop, and had not been delivered to Hambrecht. Without returning or rejecting the informal statement which was delivered to the defendant by the plaintiff on the 3d day of October, 1913, as already stated, or referring thereto, the general adjuster of the defendant, Mr. Nichols, on the 16th day of October, 1913, wrote the plaintiff as follows:—

"Referring to loss by fire of recent date to property described in policy No. 2457663 issued to you by this company, we desire to say that information comes to us to the effect that prior to the issue of our policy you ceased to be and never thereafter became the sole and unconditional owner of the property in said policy described. It is not the wish of this company to act or refrain from acting on misinformation, and if it appears to you that we have been misinformed, we shall be glad to be set right by you. Assuming, however, in the absence of information to the contrary, that the facts are as stated to us, we are taking no steps looking to an adjustment."

Thereupon the plaintiff employed one Freeman, an attorney, who called upon Nichols three or four days after the 16th of October, and according to his testimony was informed by Nichols that the company had a sworn statement from a man who claimed to own part of the boat that was burned, and for that reason "we decline to acknowledge any liability." Mr. Freeman says that after a brief conversation he left and reported "those facts" to the plaintiff. He then further testified that Nichols informed him that the plaintiff had not filed "a sufficient proof of loss," and said that the plaintiff had "sent down a paper in which he alleged a certain claim," and that the substance of Nichols' statement was that "he was not satisfied with the formality of the paper that he had," and that the company "denied any liability on account of this sworn statement," but that the statement was not exhibited to him at that time. It appears that under date of September 30, 1913, Hambrecht wrote the company, drawing attention to the policy and to the fact that there had been a total

loss by fire, and notifying the company that he had "a lien or claim upon" the policy to the extent of \$500, and requesting that the company retain that sum out of any moneys due to the plaintiff, and pay the same to him. Hambrecht also transmitted to the defendant a copy of the plaintiff's agreement with him for the construction of the houseboat. The company evidently wrote Hambrecht on the 4th of October, requesting leave to inspect the original agreement, for on the 6th he wrote the company, offering to permit such inspection. The evidence shows that some one representing the company called on him, but it does not expressly appear whether the original agreement was exhibited. There is no evidence that the defendant had any information with respect to Hambrecht's claim at the time it wrote the letter of October 16th, other than Hambrecht's letter and copy of plaintiff's agreement with him, and the testimony of Freeman to the effect that Nichols claimed at their first interview to have a sworn statement from Hambrecht, and that at their second interview such sworn statement was read to him.

No information was given to the defendant with respect to the plaintiff's ownership of the property, and there were no further negotiations between the parties with respect thereto until long after the expiration of the period within which, by the terms of the policy, plaintiff was required to furnish sworn proof of loss, and there was no attempt by the plaintiff to furnish any further proof of loss until the 28th day of January thereafter. In the meantime, Freeman, representing the plaintiff, again called on Nichols some five or six weeks or more after their first interview, and at that time he says Nichols read to him a sworn statement of Hambrecht claiming that he owned part of the property, and showed him the said informal statement (Exhibit 5). Freeman also testified that at the second interview he informed Nichols that Hambrecht denied having claimed ownership in the property, and said, "If this is true, I want to ask you, Mr. Nichols, to be kind enough to let us put in a formal proof of loss," to which Nichols replied that he would advise his company to do that if Freeman could satisfy him that the plaintiff "could get over the statement of the commodore [Hambrecht]," and further said that he desired to see justice done, and that, if Freeman could satisfy him that plaintiff "can get over the commodore's statement, I will ask the company," and that he did not know whether the company would do it, but that the company had always done what he asked, and finally said, "I will ask them if you think it can be done; you go home and think it over." Freeman also testified that he had been informed by Nichols that Hambrecht on September 30th "over his own signature in the paper drawn by his own lawyer and repeated again on October 26th had made claim under the agreement between himself and Lloyd for all the insurance money."

After the last interview between Freeman and Nichols, the plaintiff employed Messrs. Chambers & Chambers, who were the attorneys for Hambrecht, and in his behalf had drafted a notice of claim which he made against the company, and applied to the company for blanks upon which to make formal proof of loss, and his application was denied, and thereupon he prepared and swore to a formal proof of loss on the 28th day of January, 1914, and his attorneys transmitted the same to the company; but that proof of loss contains no statement with respect to the ownership of the property. Under the same date, the plaintiff wrote the defendant, referring to the fire loss, and saying, "I desire to say that the information which you have received has misinformed you; I was at all times, up to the time of the fire, the sole and unconditional owner of the property described in the policy." On the 9th of February thereafter, Nichols, as general adjuster of the defendant, wrote Messrs. Chambers & Chambers, acknowledging the receipt of the sworn statement of the plaintiff with respect to the fire loss, and his letter, and a communication from them, and stating that the papers had been referred to the company's attorney, to whom any communication in the matter should be addressed. This sworn statement was retained and produced on the trial by the attorney for the defendant, and no notice of its rejection for not having been presented in time, or for its insufficiency, was given to the plaintiff.

The learned trial court left it to the jury to determine whether or not the defendant's letter of October 16th, in the light of the attending circumstances, was a denial of liability, and instructed them that, if it was, it constituted a waiver of a compliance with the policy with respect to proof of loss, for the reason that the interest in the property claimed by Hambrecht did not affect the plaintiff's right of recovery, and at the request of the attorney for the defendant instructed them that, if it was not a denial of liability, there could be no recovery.

[1-3] The evidence showed that prior to the fire Hambrecht had paid the plaintiff \$500 on account of the construction of the houseboat. It is quite clear, I think, that, notwithstanding the agreement between the plaintiff and Hambrecht for the construction of the houseboat, the plaintiff remained the unconditional and sole owner of the property within the provision of the policy on that subject. It is well settled that such a provision with respect to ownership relates to the quality of the title of the insured, and not to the question of liens or incumbrances. *Browning vs. Home Ins. Co.*, 71 N. Y. 508, 27 Am. Rep. 86; *Wood vs. American Fire Ins. Co.*, 149 N. Y. 382, 44 N. E. 80, 52 Am. St. Rep. 733; *Haight vs. Continental Ins. Co.*, 92 N. Y. 51; see, also, *American Artistic Gold Stamping Co. vs. Glens Falls Ins. Co.*, 1 Misc. Rep. 114, 20 N. Y. Supp. 646. It is perfectly plain that no title to the boat-building shop, or to

the material used or to be used in the construction of the house-boat, passed to Hambrecht under the agreement between him and the plaintiff, and therefore the plaintiff remained the owner of the property at the time the policy was issued. The only incumbrance, which by the terms of the policy would defeat the liability of the defendant, was an incumbrance by chattel mortgage. Although doubtless, in construing the provisions of a standard policy, the terms of which have been prescribed by the Legislature, the former rule of strict construction (see *Baley vs. Homestead Fire Ins. Co.*, 80 N. Y. 21, 36 Am. Rep. 570) no longer obtains, yet the plain provisions of the contract should not be extended by construction.

The provisions with respect to an incumbrance by chattel mortgage relate to a title or interest created by a particular instrument, the nature and effect of which has often been declared by our courts as passing the legal title, leaving only an equity of redemption in the mortgagor (*Parshall vs. Eggert*, 54 N. Y. 18; *Woodward vs. Republic Fire Ins. Co.*, 32 Hun, 365); and therefore an incumbrance by chattel mortgage, as used in the policy, should not be construed as embracing an equitable lien or interest in the property, which at most is all that Hambrecht acquired (*Monongahela Ins. Co. vs. Batson*, 111 Ark. 167, 163 S. W. 510; *Bonsey vs. Amee*, 8 Pick. [Mass.] 236; *Jones on Chattel Mortgages*, page 13). It is not necessary to express an opinion with respect to the precise right or interest acquired by Hambrecht by virtue of his agreement with the plaintiff. It is sufficient that such interest, whatever it was, did not constitute an incumbrance by chattel mortgage, within the purview of the policy.

[4] There was some indefinite testimony given by Freeman with respect to a sworn statement by Hambrecht having been read to him; but Hambrecht was a witness upon the trial, and the effect of his testimony is that the only claim he made was under the agreement between him and the plaintiff, and a copy of that agreement was before the defendant's adjuster when he wrote the letter which is claimed to constitute a definite and unequivocal denial of liability if the facts were as represented to him. Nichols was not called as a witness, and it must therefore be assumed that the only information the defendant had with respect to Hambrecht's claim was that which he made by the letter of September 30th, and which was based on the agreement between him and the plaintiff. The plaintiff could not deny the making of that agreement, and, that being so, the effect of the defendant's letter was, we think, to notify him that the defendant disclaimed liability on the policy, and would take no step looking to an adjustment of the loss. In that view, the letter constituted a definite and unequivocal denial of liability, which relieved the plaintiff from any obligation to comply with the provisions of

the policy with respect to proof of loss. *Flaherty vs. Continental Ins. Co.*, 20 App. Div. 275, 46 N. Y. Supp. 934; *Lang vs. Eagle Fire Ins. Co.*, 12 App. Div. 39, 42 N. Y. Supp. 539; *Dobson vs. Hartford Fire Ins. Co.*, 86 App. Div. 115, 83 N. Y. Supp. 456; *Brink vs. Hanover Fire Ins. Co.*, 80 N. Y. 108; *Chamberlain vs. Ins. Co. of North America*, 3 N. Y. Supp. 701 [Reported in full in the New York Supplement; reported as a memorandum decision without opinion in 51 Hun. 636]; *Miles vs. Casualty Co. of America*, 115 N. Y. Supp. 1, affirmed 120 N. Y. Supp. 1135.

It is therefore unnecessary to consider whether there could be a recovery on the theory that the defendant should be deemed to have accepted the original statement (Exhibit 5) delivered to it on the third of October as a sufficient proof of loss, or whether, in the circumstances, it could be held on the theory that it waived service of proof of loss within the period specified in the policy, and accepted the plaintiff's sworn statement of January 28, 1914, as a sufficient proof of loss.

It follows that the judgment and order should be affirmed, with costs. Order filed. All concur.

SUPREME COURT OF NEW YORK.
APPELLATE DIVISION, FIRST DEPARTMENT.

ADOLPH BOSKOWITZ, RESPONDENT,

vs.

THE CONTINENTAL INSURANCE COMPANY, APPELLANT.
(No. 277.)*

Appeal from judgment entered at trial term in favor of the plaintiff upon a directed verdict. Affirmed.

Before John Proctor Clarke, P. J.; Frank C. Loughlin, Francis M. Scott, Victor J. Dowling, and Alfred R. Page, JJ.

William B. Ellison, for Appellant.
Max D. Steuer, for Respondent.

PAGE, J.

After the case had been submitted to the jury and the jury had deliberated upon the issues for some time without reaching an agreement, both parties moved for a direction of the verdict in their favor, and neither party asked to have any question of fact submitted to the jury. Thereupon, the trial justice directed a verdict for the plaintiff in the sum of \$7,401.27.

* Decision rendered, November, 1916. From a certified transcript.

The action was brought to recover on a policy of fire insurance upon the property of the plaintiff, known as 704 and 706 Broadway. The total amount of insurance was \$160,000 and was divided among the following companies:—

Scottish Union	\$75,000
Fire Association of Philadelphia.....	25,000
Sun Insurance Office.....	25,000
Home Insurance Company	10,000
And the defendant company.....	25,000

Actions have been brought against each of these companies to recover the proportionate amount of the alleged loss, and it was stipulated that all of these actions should abide the result of this case. Certain items of damage were agreed upon. The third item of damage claimed by the plaintiff to piers and north and south walls estimated to be replaced at \$36,217, is disputed by the defendant, its claim being that the amount is grossly exaggerated, and furthermore, that damages to the piers and north and south walls referred to are expressly excluded under the policies sued on. The appellant also presents three other contentions to the court on this appeal. First, that by the terms of the policy the loss, if any, was made payable to a person other than the plaintiff; and Second, that the plaintiff was guilty of fraud and false swearing; Third, that conceding the liability of the defendant, the damages awarded the plaintiff are grossly excessive.

Before entering upon the consideration of those questions presented by the appeal, it is necessary to consider the effect of the direction of the verdict after a motion to that effect by both parties, neither party requesting the submission of any fact to the jury. The appellant takes the position that this was no more than the waiving of a jury and the trial of the issues by the court, and he relies upon § 993 of the Code of Civil Procedure as giving to this court power to review all questions of fact and of law. This, however, was not a trial of the case without a jury, but the trial of the case by a jury in which a verdict had been directed, and therefore § 993 does not apply.

In the case of Trimble vs. N. Y. C. & H. R. R. Co., 162 N. Y. 84, the Court of Appeals considered at length, reviewing a number of prior decisions, the result of a direction of a verdict where both sides had in effect moved for a direction, and held that where a verdict has been directed in favor of the plaintiff, although the defendant excepted thereto, all the controverted facts and all inferences in support of the judgment entered thereon will be deemed conclusively established in his favor.

In Mullen vs. Quinlan & Co., 195 N. Y. 109, 113, at the conclusion of the plaintiff's case defendant's counsel moved for a nonsuit and the motion was denied and exception taken. The defendant then rested, offering no evidence, whereupon the plain-

tiff moved for a direction of the verdict in its favor. The trial court granted the motion and the defendant excepted. The court said: "As neither party had asked to go to the jury upon any question of fact, the court was authorized to determine the case, as one of law, upon the facts in evidence, and if there was any evidence to sustain the determination made, it is conclusive upon the parties. The defendant, in effect, by requesting the court to determine the case upon his motion for a nonsuit, treated the questions as purely legal and acquiesced in their disposal by the court. The exception to the direction of a verdict for the plaintiff avails, only, to bring up the question of the sufficiency of the evidence."

And again in *Jacobus vs. Jamestown Mantel Co.*, 211 N. Y. 154, the question involved was as to the power of the treasurer of the corporation to execute a promissory note. The court states in its opinion certain questions of fact which were presented by the evidence, and then says: "The plaintiff at the trial insisted that the court direct a verdict, and it having directed a verdict for the defendant, the plaintiff is bound by the decision of the court upon all questions of fact then open for its determination. There is evidence on which the trial court was authorized to make the findings necessary on which to base its direction of a verdict for the defendant," and affirmed the judgment. From these authorities it would appear that in our review of the judgment in this case we cannot consider questions as to the credibility of the witnesses or the weight of the evidence, but can only reverse or modify the judgment if there is no evidence tending to sustain it or if otherwise it is contrary to law.

The policy in this case is the usual standard form in which the company "does insure" Adolph Boskowitz against all direct loss or damage by fire. Attached thereto is a rider. The parts thereof material to this appeal are as follows: "25,000 on the brick and stone building, excluding cost of the excavations and the foundations of the building below the level of the ground, situate at No. 704-706 Broadway in the Borough of Manhattan, City of New York, * * * loss if any, payable to Adolph Boskowitz, as trustee."

In the proof of loss presented, it is stated that the sole owner in fee of the buildings covered by said policy, and of the ground on which said building stood is the assured, and that the only encumbrance on the property is a mortgage in the sum of \$200,000 to Adolph Boskowitz as trustee. The appellant's claim, first, that by the terms of the policy the loss, if any, was made payable to a person other than the plaintiff, and second, that the damage to the piers and north and south walls are expressly excluded under the policy by the provisions of the rider "excluding cost of excavations and foundations of building below the level of the ground," and furthermore, third, that if the defendant is

liable for damage to the piers the damage awarded plaintiff is grossly excessive, and also it is charged that the plaintiff is guilty of fraud and false swearing, the policy providing that the policy should be void in case of any fraud or false swearing by the insured touching any matter relating to this insurance or the subject thereof whether before or after the loss. There is nothing in the contention that by the terms of the policy the loss, if any, was made payable to a person other than the plaintiff, and for that reason the plaintiff could not maintain the action. In the first place, the contract is made with the plaintiff as the assured. (See Carr vs. Providence-Washington Ins. Co., 38 Hun. 86, 95; Carr vs. Security Ins. Co., 109 N. Y. 504, 511.) The loss is made payable, if any, to a person of the same name with the added words "as trustee." These words are clearly mere words of description and do not designate a representative capacity for the reason that no *cestui que* trust is named. The trust is therefore a dry trust. The identity of the persons would be assumed from the identity of names. But if we should conclude that these were different persons, the objection of non-joinder not having been raised by demurrer or answer, is waived. (Code of Civil Procedure, §§ 488 and 499.)

The appellant claims that the damage to the piers and north and south walls is expressly excluded by the terms of the rider.

The question here to be considered is, were these piers a part of the foundation? This was the principal question litigated. Witnesses were called on both sides, those of the plaintiff testifying that there was a well-known distinction between "foundations"; that is, the footing of concrete, etc., and the "foundation walls" which rested on that footing. The Building Code of the City was introduced, § 25 of which refers to foundations and § 26 to foundation walls (See p. 306 et seq.) There being, therefore sufficient evidence, if accepted to support the finding that the piers and east and west walls were not excepted from the policy, we cannot interfere with the judgment on that score.

The appellant also claims that the damages were excessive, the rule of damages as provided by the policy is as follows: "The loss or damage shall in no event exceed what it would then cost the insured to repair or replace the same with material of the like kind and quality." (McCready vs. Hartford Fire Ins. Co., 61 App. Div. 584). Defendant's claim, that it would cost less to repair by binding the cracked piers with irons or cables and surrounding them with concrete, and this it claims was what was done by the plaintiff. But the damage that the defendant agreed to pay was what it would cost "to repair or replace the same with materials of the like kind and quality." The plaintiff gave evidence of that cost, and that was the amount included in the judgment.

The claim of false swearing is predicated upon the statement

in the proof of loss that the cash value of the building was \$190,000, whereas in proceedings for reduction of tax assessment he stated it to be worth in 1913, \$95,000; in 1914, \$90,000; in 1915, \$68,000. Here the plaintiff claims that there were two entirely different measures of value. The insurance value was cost of reproduction, and he proved that the building actually cost \$200,000, while the value for taxation was sale value based on rental and other elements, one of which was that property in this neighborhood had greatly depreciated by reason of the exodus of business firms, and another a comparison with the assessed values of other properties.

In any event I am not of opinion that the false swearing in other proceedings unrelated to the insurance transaction has any bearing under the provision of the policy.

The only possible relevance or materiality of the valuation in tax matter was to affect the credibility of the plaintiff which is not now an element in this case, however it might have been for the consideration of the jury.

The judgment should be affirmed with costs.

All concur.



SUPREME COURT OF NORTH CAROLINA.

JOHNSON & STROUD

vs.

RHODE ISLAND INS. CO. (No. 186).*

1. INSURANCE—CONTRACT—CONSTRUCTION AGAINST INSURER.

Contracts of insurance are construed against the insurer, and in favor of the insured, and this is so, notwithstanding the adoption of a standard form of insurance.

(For other cases, see Insurance, Cent. Dig. § 292; Dec. Dig. § 146[4].)

2. CONTRACTS—CONSTRUCTION IN FAVOR OF VALIDITY.

Where the language of a contract admits of two constructions, one of which is legal and binding, and the other not, the first construction will be adopted.

(For other cases, see Contracts, Cent. Dig. § 734; Dec. Dig. § 153.)

3. INSURANCE—CONTRACTS—FORFEITURE.

Courts look with disfavor upon forfeitures, and the trend of modern authority is that a stipulation in a policy which might avoid it does

* Decision entered, Oct. 4, 1916. 90 S. E. Rep. 124.

not do so if it in no way contributes to the loss, and if the conditions provided for therein do not exist at the time of the loss.

(For other cases, see Insurance, Cent. Dig. §§ 702, 763, 828; Dec. Dig. § 309.)

4. INSURANCE—TORNADO INSURANCE—CONSTRUCTION—RISK—CONDITION OF PROPERTY.

Under a policy of tornado insurance purporting to insure a building with a metal roof, and inclosed addition thereto, occupied as a warehouse, providing that the insurer should not be liable for damage to the building or its contents unless it was entirely inclosed and under roof, the insurer was not to be liable until it was inclosed and under roof, but, when it was so inclosed, its liability attached.

(For other cases, see Insurance, Cent. Dig. § 1127; Dec. Dig. § 423.)

5. INSURANCE—CONDITION OF PROPERTY—KNOWLEDGE OF AGENT—EFFECT.

The knowledge of the agent of an insurer who issued and delivered a policy to the insured, excepting risk if warehouse was not inclosed, that the warehouse was not then inclosed, was to be imputed to the insurer.

(For other cases, see Insurance, Cent. Dig. §§ 96-113, 125; Dec. Dig. § 95.)

6. INSURANCE—CONDITION OF PROPERTY—KNOWLEDGE OF INSURER—EFFECT.

Where insurer issues a policy knowing the conditions then existing it cannot avoid responsibility on account of those conditions.

(For other cases, see Insurance, Cent. Dig. §§ 253-255; Dec. Dig. § 141[1].)

7. INSURANCE—CONSTRUCTION OF POLICY—POWERS OF AGENT.

The provision in a policy of insurance restricting the power of the agent to waive conditions and stipulations applies to something that occurs after the policy has been issued, and not to conditions existing at its inception.

(For other cases, see Insurance, Dec. Dig. § 90.)

Appeal from Superior Court, Pitt County; Lyon, Judge.

Action by Johnson & Stroud against the Rhode Island Insurance Company. Judgment for plaintiffs, and defendant excepts and appeals. New trial.

This is an action to recover upon two policies of tornado insurance issued by defendant company and alleged to be in force on September 3, 1913, when a storm partially destroyed the tobacco warehouse alleged to be insured. Policy No. 2105 bears date June 5, 1913, and policy No. 2106 bears date June 23, 1913, and each ran for one year from date. The premium on these policies was \$4 each, and they were in the sum of \$2,000 each. The policies purported to insure "one-story brick building, with metal roof, and inclosed addition thereto attached, including foundations, plumbing, steam, gas, and water pipes, and all permanent fixtures, occupied as a warehouse." The plaintiffs, for whom the building was insured, were contractors. Policy 2106 had attached thereto and forming a part thereof a 50 per cent coinsurance clause. The defendant contends that policy 2105 had a coinsurance clause, but this was denied by the plaintiffs.

The defendant contended that neither of the policies was ever in force under the following provisions of the policy, to wit:—

"This company shall not be liable for loss or damage to buildings or their contents in process of construction, or reconstruction, unless same

are entirely inclosed and under roof, with all outside doors and windows permanently in place."

And:—

"No officer, agent, or other representative of this company shall have power to waive any provision or condition of this policy, except such as by the terms of this policy may be the subject of agreement indorsed thereon, or added thereto, and as to such provisions and conditions, no officer, agent, or representative shall have such power or be deemed or held to have waived such provisions or conditions, unless such waiver, if any, shall be written upon or attached to the policy."

The warehouse was not inclosed and under roof when the policies were issued, but was at the time of loss.

The defendant pleaded that the policies had been canceled before the loss, and offered evidence in support of its plea. The defendant excepted to the admission, over objection of the defendant, of statements alleged to have been made by the agent, Wilkinson, after the storm, affecting the company's liability, and alleged to have been made in the presence of the plaintiff Stroud and of the witnesses Monk and Smith.

The statement alleged to have been made in the presence of Stroud was as follows:—

"That he [Wilkinson] said he thought the insurance ought to be canceled; that the insurance was canceled morally, but in the eyes of the law it was in full force, and he didn't think we [plaintiffs] ought to make his company pay the loss."

And the further statement:—

"That he [Stroud] heard Wilkinson say, after the storm of September 3d: 'I have \$4,000 insurance on this building, but morally I do not think my company ought to have to pay, but in the eyes of the law they are in full force.'"

The statement alleged to have been made in the presence of the witness Monk was as follows:—

"Monk, I have \$4,000 insurance on this building in full force. From the standpoint of merit and principle, I do not feel like my company ought to pay it. Mr. Stroud asked me to cancel that insurance on Friday, but I did not do it. You will get your insurance."

The statement alleged to have been made in the presence of Smith was as follows:—

"That the policies were not canceled, but morally the risk would not hold good, as they had been ordered canceled by Stroud."

The agent of the defendant testified to the cancellation of the policies, but this evidence was offered after the evidence introduced by the plaintiffs of the declarations of the agent above set out. The agent also testified that he failed to attach the coinsurance clause to policy 2105, by mistake, that after its delivery he mailed a coinsurance clause to the plaintiff, sent one to the office at Raleigh, and retained one in his own office, and that he at the same time made an entry upon the registry of his office of having done so. The defendant offered the registry in corroboration of the agent. This was excluded and the defendant excepted. The coinsurance clause would reduce the amount of the liability of the defendant.

His honor charged the jury on the seventh issue as follows:—

"That is a disputed issue. You have heard the evidence on both sides, and I have given you the contentions on both sides, and it is a question of fact for you to determine. If you find from the evidence that Stroud, one of the plaintiffs, directed the agent to cancel the policies on the 25th of August, and again on the 29th of August, and that the policies were canceled at his direction, by his orders, then you would answer that issue 'Yes,' notwithstanding the fact that the policies themselves were not actually delivered; but if you find, according to the contentions of the plaintiffs, that the policies were not canceled, and that the company

treated them as still in force by the declarations of the agent, Wilkinson, made after the storm, then you would answer that issue 'No.'"

The jury returned the following verdict:—

"(1) Did the defendant execute and deliver to the plaintiffs its two policies of insurance, Nos. 2105 and 2106, as alleged in the complaint? Answer: Yes.

"(2) Did the plaintiffs accept said policies upon condition that the defendant should not be liable for loss or damage to buildings, or their contents, in process of construction, or reconstruction, unless same are entirely inclosed, and under roof, with all outside doors and windows permanently in place, as alleged in the answer? Answer: Yes.

"(3) Was said building, at the time of the injury complained of, in process of construction, and entirely inclosed and under roof, with all outside doors and windows permanently in place? Answer: Yes.

"(4) Did policy No. 2105 have attached thereto and forming a part thereof, a coinsurance clause? Answer: No.

"(5) Had the plaintiffs, on September 3, 1913, delivered the warehouse described in the policies to J. Y. Monk, the owner thereof, and was the owner, on said date, in full control and occupation of the same, as alleged in the answer? Answer: No.

"(6) If the plaintiffs had delivered the possession of said warehouse to J. Y. Monk, did the defendant company, or its agent, have notice or knowledge of the same before the collection of the premium therefor? Answer: _____.

"(7) Had the plaintiffs, prior to September 3, 1913, caused the policies in suit to be canceled, as alleged in the answer? Answer: No.

"(8) What damage was done to said building by reason of said storm? Answer: \$1,496.80."

Judgment was entered upon the verdict in behalf of the plaintiffs, and the defendant excepted.

Albion Dunn, of Greenville, for Appellant.
Harding & Pierce, of Greenville, for Appellees.

ALLEN, J.

The warehouse covered by the policies of insurance was not inclosed and under roof at the time the policies were issued, and the defendant bases its motion for judgment of nonsuit upon this fact, contending, as the policies provide that the company shall not be liable for any loss or damage to buildings in process of construction or reconstruction unless the same are entirely inclosed and under roof, that there is no liability on the defendant, although the warehouse was inclosed and under roof at the time of the loss.

[1] The rule of construction prevails almost universally that contracts of insurance are construed against the insurer and in favor of the insured, and this has not been changed by the adoption of a standard form of insurance. Wood vs. Insurance Co., 149 N. Y. 385, 44 N. E. 80, 52 Am. St. Rep. 733; Gazzam vs. Insurance Co., 155 N. C. 338, 71 S. E. 434, Ann. Cas. 1912C, 362; Cottingham vs. Insurance Co., 168 N. C. 265, 84 S. E. 277, L. R. A. 1915D, 344. In the last case the court says:—

"The terms of a policy of insurance are construed against the insurer and in favor of the insured, and this is true although a standard form of policy has been adopted under legislative

enactment. *Gazzam vs. Insurance Co.*, 155 N. C. 330 [71 S. E. 434, Ann. Cas. 1912C, 362]."

[2] It is also a rule of construction applicable to all contracts that, if the language admits of two constructions, one of which is legal and binding, and the other not, the first will be adopted. 6 R. C. L. 839.

[3] The courts also look with disfavor upon forfeitures (*Skinner vs. Thomas*, 171 N. C. —, 87 S. E. 976), and the trend of modern authority is that a stipulation in a policy which might avoid it does not have this effect if it in no way contributes to the loss, and if the conditions provided for in the stipulation do not exist at the time of the loss (*Cottingham vs. Insurance Co.*, 168 N. C. 264, 84 S. E. 274, L. R. A. 1915D, 344). In this last case a policy of insurance provided that the policy would be void if the property insured became incumbered by a chattel mortgage, and it was held that the amount of the insurance could be collected from the company, although the insured had executed a chattel mortgage upon the property, which was, however, canceled before the loss.

[4] If these principles are applied to the clause of the policy under consideration, it would seem that the proper interpretation is that the company was not to be liable until the warehouse was inclosed and under roof, and that when it was inclosed and under roof its liability would attach. The clause indicates clearly that the company intended to insure a building in process of construction, and the language upon which the defendant seeks to escape liability was only intended to fix the time and the conditions when the defendant would be liable. This construction gives some force and life to the policies, and saves the defendant from the imputation of having issued a worthless policy.

[5] If, however, the stipulation refers to conditions existing when the policy issued, the agent of the company who issued the policies and delivered them to the plaintiffs had full knowledge that the warehouse was not at that time inclosed and under roof and this knowledge is imputed to the defendant company.

In *Bergeron vs. Insurance Co.*, 111 N. C. 47, 15 S. E. 883, the court quotes with approval from *May on Insurance* that:—

"Facts material to the risk, made known to the agent (or a subagent intrusted with the business) before the policy is issued, are constructively known to the company, and cannot be set up to defeat a recovery on the policy."

And in *Grabbs vs. Insurance Co.*, 125 N. C. 395, 34 S. E. 505:—

"It is well known that as a general rule fire insurance policies are issued in a different way from those of life insurance companies. The latter are usually issued directly from the home office, while fire insurance policies are generally sent to the local agent in blank, and are filled up, signed, and issued by him. The blanks, while purporting to be signed by the higher officers of

the company, usually have their names simply printed thereon in autographic fac simile. Under such circumstances, can it be doubted that the policy is really issued by the agent who, for all purposes connected with such insurance, is the alter ego of the insurer? That he is seems too well settled to need citation of authority, and therefore his knowledge is the knowledge of the company. We can only repeat what we have so recently said in *Horton vs. Insurance Co.*, 122 N. C. 498, 503 [29 S. E. 944, 945 (65 Am. St. Rep. 717)]: 'It is well settled in this state that the knowledge of the local agent of an insurance company is in law the knowledge of the principal; that the conditions in a policy working a forfeiture are matters of contract, and not of limitation, and may be waived by the insurer; and that such waiver may be presumed from the acts of the agent.'"

[6] The same authorities also support the position that, if the defendant issued the policy knowing the conditions existing at the time, it cannot now avoid responsibility on account of those conditions.

[7] Nor does the provision in the policy restricting the power of the agent to waive conditions and stipulations affect the application of this rule, because those restrictions are generally construed to apply to something that occurs after the policies have been issued, and not to conditions existing at the inception of the policy.

In *Grabbs vs. Insurance Co.*, *supra*, the court approves the statement in *Berry vs. Insurance*, 132 N. Y. 49, 30 N. E. 254, 28 Am. St. Rep. 548, that:—

"Conditions which enter into the validity of a contract of insurance at its inception may be waived by agents, and are waived if so intended, although they remain in the policy when delivered."

And in *Wood vs. Insurance Co.*, which is approved in *Gazzam vs. Insurance Co.*, 155 N. C. 336, 71 S. E. 434, Ann. Cas. 1912C, 362, the court says:—

"The restrictions inserted in the contract upon the power of the agent to waive any condition, unless done in a particular manner, cannot be deemed to apply to those conditions which relate to the inception of the contract when it appears that the agent has delivered it and received the premiums with full knowledge of the actual situation. * * *

"The principle is not a new one, and it has not been shaken by any decisions of this court made since the adoption of the standard policy."

And again, in *Forward vs. Insurance Co.*, 142 N. Y. 387, 37 N. E. 616, 25 L. R. A. 637:—

"It could not be supposed that it intended to deliver to the insured a policy which it knew to be void."

We are therefore of opinion that, whether the clause in the

policy refers to conditions existing at the time it was issued or not, it was not necessarily fatal to the plaintiffs' cause of action that the warehouse was not inclosed and under roof at the time the policies were issued, and that the motion for judgment of nonsuit was properly denied.

[8, 9] We are, however, further of opinion that error was committed which entitles the defendant to a new trial.

The authorities in this state are all to the effect that the declarations of the agent made after the event, and as mere narrative of a past occurrence, are not competent against the principal. *Smith vs. Railroad*, 68 N. C. 115; *Rumbough vs. Improvement Co.*, 112 N. C. 751, 17 S. E. 536, 34 Am. St. Rep. 528; *Morgan vs. Benefit Society*, 167 N. C. 265, 83 S. E. 479.

This evidence of the declarations of the agent would have been competent if the agent had been first introduced and had testified to the cancellation of the policies as it would have had the effect of impeaching his evidence, and it may be that the order of the introduction of the evidence would not be fatal, but it further appears that his honor not only failed to restrict the effect of the evidence, but he gave it the force of substantive evidence in his charge, which, in this particular, is excepted to. It was also competent for the defendant to introduce the record made by the agent in corroboration of his evidence.

We call attention to the discussion of cancellation, which will arise upon the new trial, which will be found in *Manufacturing Co. vs. Assurance Co.*, 161 N. C. 98, 76 S. E. 865.

For the errors pointed out, a new trial is ordered.
New trial.

SUPREME COURT OF VERMONT.

BEECHER

vs.

VERMONT MUT. FIRE INS. CO.*

INSURANCE—FORFEITURE FOR BREACH OF CONDITION— BUILDING BECOMING VACANT—EFFECT OF RESUMPTION OF OCCUPANCY.

A provision in an insurance policy that it shall be void if the property covered is unoccupied for a period of ten days, without the company's consent, merely suspends the insurance during the unoccupancy, and the policy is revived by a reoccupancy before a fire.

(For other cases, see *Insurance, Cent. Dig. § 768; Dec. Dig. § 323[2].*)

* Decision rendered, Oct. 10, 1916. 98 Atl. Rep. 917.

Exceptions from Essex County Court; L. S. Slack, Judge.

Action by Albert R. Beecher against the Vermont Mutual Fire Insurance Company. Verdict and judgment for plaintiff, and defendant excepts. Affirmed.

Argued before Munson, C. J., and Watson, Haselton, Powers, and Taylor, JJ.

Porter, Witters & Harvey, of St. Johnsbury, for Plaintiff.
Fred L. Laird, of Montpelier, for Defendant.

POWERS, J.

The policy carried by this plaintiff in the defendant company contained a provision that it should be void if the property covered should be unoccupied for a period of ten days without the consent of the company. A fire having occurred, this suit was brought upon the policy, and the company here defends on the ground of a violation of this provision. The policy ran for five years from its date, and on various occasions before the fire the buildings were unoccupied for the specified period, though they were occupied by the assured at the time of the fire. The case as presented presupposes the validity of this condition in the circumstances shown; but in our view the question of its validity is of vital importance. Some of the cases like Hoover vs. Ins. Co., 93 Mo. App. 111, 69 S. W. 42, Moore vs. Phoenix Ins. Co., 64 N. H. 140, 6 Atl. 27, 10 Am. St. Rep. 384, Id., 62 N. H. 240, 13 Am. St. Rep. 556, Dolliver vs. Granite State Fire Ins. Co., 111 Me., 275, 89 Atl. 8, 50 L. R. A. (N. S.) 1106, Ann. Cas. 1916C, 765, rigorously adhere to a literal interpretation of such provisions, and deny a recovery, though the premises are reoccupied before the fire occurs. But we do not hesitate to align ourselves with Ins. Co. of No. Am. vs. Garland, 108 Ill. 220, Silver vs. London Ass'n Corp., 61 Wash. 593, 112 Pac. 666, Ins. Co. of No. Am. vs. Pitts, 88 Miss. 587, 41 South. 5, 7 L. R. A. (N. S.) 627, 117 Am. St. Rep. 756, 9 Am. Cas. 54; Born vs. Home Ins. Co., 110 Iowa, 379, 81 N. W. 676, 90 Am. St. Rep. 300, and Sumter Tobacco Warehouse Co. vs Phoenix Ins. Co., 76 S. C. 76, 56 S. E. 654, 10 L. R. A. (N. S.) 736, 121 Am. St. Rep. 941, 11 Ann. Cas. 780, by holding that this provision, rightly construed, merely suspends the insurance during the unoccupancy, and that the policy is revived by a reoccupancy before the fire. Such a construction accords with the real purpose of the provision, and harmonizes with the doctrines of this court in kindred cases. To hold otherwise is to give the company an unconscionable advantage over its patrons, by allowing it to retain the full premium, a part of which is unearned, and enabling it to take advantage of an unsuspected forfeiture through an innocent violation of one of the numerous conditions inserted in the policy, though it be a most trivial matter and wholly unconnected with the fire. We cannot believe that the company seriously expected

such a result when the language of the policy was selected. Certainly, it would be well-nigh impossible to keep within the literal terms of the policy under present day living conditions.

Judgment affirmed.

SPRINGFIELD FIRE & MARINE INS. CO. *vs.* FIELDS
ET AL. (No. 23117.)*
(Supreme Court of Indiana.)

2. INSURANCE—FIRE INSURANCE—PROOF OF LOSS.

Where a fire insurance policy requires preliminary proofs of loss, a denial of liability by the insurer waives a performance of the act prescribed. (For other cases, see Insurance, Cent. Dig. §§ 1391, 1392; Dec. Dig. § 559[1].)

3. INSURANCE—FIRE INSURANCE—ACTION—ATTORNEY'S FEES.

Under Acts 1911, c. 216, providing that where policies require preliminary proofs of loss insurer may recover attorney's fees where liability is not wholly denied, and where after preliminary proofs of loss and a demand for appraisement, the selection of appraisers, and their failure to agree, the selection of a second set of appraisers and their disagreement, there is a failure to select a second umpire within the prescribed time, where proof of loss under a fire insurance policy was waived by denial of liability, attorneys' fees could not be recovered.

(For other cases, see Insurance, Cent. Dig. § 1791; Dec. Dig. § 666.)

Appeal from Circuit Court, Monroe County; James H. Wilson, Judge. Action by Len S. Fields and others against the Springfield Fire & Marine Insurance Company. Judgment for plaintiffs, and defendant appeals. Affirmed on condition that plaintiffs remit a portion of the judgment; otherwise, reversed with instructions to grant a new trial.

Bates, Harding, Edgerton & Bates, of Chicago, Ill., and J. E. Henley, of Bloomington, for Appellant.
Edwin Corr, of Bloomington, for Appellees.

* Decision rendered, Oct. 10, 1916. 113 N. E. Rep. 756.

YORK *vs.* SUN INS. OFFICE. (No. 9103.)*
(Appellate Court of Indiana, Division No. 2.)

1. INSURANCE—DELIVERY OF POLICY—EFFECT.

An unconditional delivery of a policy by the insurer's agent to the insured amounts to a waiver of advance payment of premium, especially

* Decision rendered, Oct. 24, 1916. 113 N. E. Rep. 1021.

where no condition of the policy makes such payment a condition precedent to liability, and the relation of debtor and creditor then arises. (For other cases, see Insurance, Dec. Dig. § 186[2].)

2. INSURANCE—CANCELLATION OF POLICY—RETURN BY MAIL.

While mere return of policy by mail to the insurer's agent does not alone amount to cancellation under the insured's right to cancel, yet, if returned with the obvious purpose of cancellation, receipt by the insurer's agent would be a cancellation.

(For other cases, see Insurance, Cent. Dig. § 504; Dec. Dig. § 232.)

3. INSURANCE—RIGHT OF INSURER TO CANCEL—WAIVER.

When an insurer knows of a right entitling it to declare forfeiture of a policy, and fails to assert it, the law will regard it as having waived the right.

(For other cases, see Insurance, Cent. Dig. § 1027; Dec. Dig. § 388[3].)

4. INSURANCE—RIGHT OF INSURER TO CANCEL—WAIVER.

Where insured returned a policy calling attention to change of circumstances which would forfeit it, and asking a new policy on different terms, he was chargeable, after a reasonable time had elapsed, with notice of cancellation and refusal to rewrite the policy, and the insurer was not liable for loss, although its agent failed to notify insured of such refusal.

(For other cases, see Insurance, Cent. Dig. § 504; Dec. Dig. § 232.)

5. INSURANCE—RIGHT OF INSURER TO CANCEL—WAIVER—REASONABLE TIME.

In such case, where insured and the agent lived in the same city, and thirty-three days elapsed between return of the policy and loss, a reasonable time had elapsed.

(For other cases, see Insurance, Cent. Dig. § 504; Dec. Dig. § 232.)

Appeal from Superior Court, Marion County; Clarence E. Weir, Judge.

Action by Phineas H. York, receiver of the Mahogany Interior Trim Company, against the Sun Insurance Office. Judgment for defendant, and plaintiff appeals. Affirmed.

Frank G. West, of Indianapolis, for Appellant.
James W. Noel, of Indianapolis, for Appellee.

METROPOLITAN FIRE INSURANCE CO. vs.

MIDDENDORF ET AL.*

(Court of Appeals of Kentucky.)

1. INSURANCE—INSURANCE COMPANIES—ASSETS AND RECEIVERS—JURISDICTION OF COURT—STATUTE.

A circuit court had jurisdiction to appoint a receiver for a fire insurance company which had never been granted a license to do business in the state, and had only been engaged in selling its stock; Ky. St. § 752,

* Decision rendered, Oct. 27, 1916. 188 S. W. Rep. 790.

relative to examination of any insurance company by the Insurance Commissioner upon request of stockholders, creditors, policyholders, etc., referring only to such companies as are actually doing an insurance business, so that exclusive jurisdiction was not in the insurance department.

(For other cases, see Insurance, Cent. Dig. §§ 8, 58-61; Dec. Dig. § 50.)

3. INSURANCE—INSOLVENCY AND RECEIVERS—RIGHT OF STOCKHOLDERS TO RECEIVERSHIP.

Where an insurance company, unlicensed to do business in the state, contracted with an agent to sell its stock, agreeing to pay him 30 per cent of the moneys received, and such agent, incorporating a trust company to handle the business, proceeded to sell more stock than the insurance company was authorized to issue, at twice par value or even more, taking one-half the price in cash and one-half in notes, misrepresenting to purchasers that the notes would not have to be paid, but would be extinguished by dividends on the stock, and that the cash payment was to be set aside as a surplus fund, thereafter diverting 60 per cent of the cash received, purchasers of stock from such agent were entitled to have a receiver appointed, since where corporate trust funds or properties are being mismanaged and are in danger of being lost to the stockholders and creditors through collusion of such officers, equity will assume charge of the property through a receiver.

(For other cases, see Insurance, Cent. Dig. §§ 8, 58-61; Dec. Dig. § 50.)

Appeal from Circuit Court, Kenton County.

Suit by Fred T. Middendorf and Henry Middendorf, for themselves and others similarly situated, against the Metropolitan Fire Insurance Company. From orders appointing receivers for defendant company and the Metropolitan Trust Company, the corporations appeal. Judgment affirmed as to the insurance company, and reversed as to the trust company, with directions to set aside the order appointing a receiver for it.

H. O. Williams, of Louisville, Wm. A. Byrne, of Covington, and Jas. H. Polsgrove, of Frankfort, for Appellants.

S. D. Rouse, John T. Murphy, and Myers & Howard, all of Covington, for Appellee.



TILLEY vs. CAMDEN FIRE INS. ASS'N—IN RE TILLEY.*

(Supreme Court of Louisiana.)

1. INSURANCE—RIGHT TO PROCEEDS—MORTGAGE—STATUTORY PROVISIONS.

The assured, whose building is totally destroyed by fire, has no right to waive the benefit of the statute (Act No. 135 of 1900, and Act No. 187 of 1908) abolishing the three-quarter value clause, and agree to an adjustment on the basis of three-fourths of the value of the property destroyed, to the prejudice, and without the knowledge or consent, of a mortgage creditor in whose favor the policy contains a rider to the effect that any loss or damage ascertained and proven to be due the

* Decision rendered, June 30, 1916. Rehearing denied, Oct. 16, 1916. 72 South. Rep. 709. Syllabus by the Court.

assured under the policy shall be payable to the mortgagee as his interest may appear.

(For other cases, see Insurance, Cent. Dig. § 1441; Dec. Dig. § 580[2].)

2. INSURANCE—ACTION ON POLICY—CONDITIONS PRECEDENT.

When the proof of loss, prepared by the insurance company's adjuster, shows upon its face that the loss due the assured is the full amount of the policy of insurance, notwithstanding the insured has, through error of law, consented to settle on the basis of three-fourths of the value of the property, the mortgage creditor, in whose favor the policy bears a loss payable clause, is not required to bring a direct action to set aside the adjustment and settlement agreed to by the insured, before suing the insurance company for the full amount due under the policy.

(For other cases, see Insurance, Cent. Dig. § 1521; Dec. Dig. § 612[2].)

3. INSURANCE—LIABILITY OF INSURER—DAMAGES AND ATTORNEY'S FEES.

If the insurance company arbitrarily refuses to pay the amount which its adjuster has admitted to be due under a policy of fire insurance, except as a full and final settlement, the company is liable for 12 per cent statutory damages on the full amount adjudged to be due under the policy and a reasonable attorney's fee, according to section 3 of Act No. 168 of 1908.

(For other cases, see Insurance, Cent. Dig. § 1498; Dec. Dig. § 602.)

Certiorari to Court of Appeal, Second Circuit.

Action by R. D. Tilley against the Camden Fire Insurance Association. From a judgment of the court on appeal, reducing a judgment for plaintiff, the plaintiff prosecutes certiorari or writ of review. Judgment of the court on appeal annulled, and that of the district court reinstated and affirmed.

Elias Goldstein, of Shreveport, for Relator.

J. S. Patterson, and J. S. Atkinson, of Shreveport, for Defendant.



WIIG vs. GIRARD FIRE & MARINE INS. CO. OF PHILADELPHIA, PA.—SAME vs. AMERICAN INS. CO. OF NEWARK, N. J. (Nos. 18781, 18782.)*

(Supreme Court of Nebraska.)

INSURANCE—RISKS COVERED—FALL OF BUILDING.

A policy of insurance contained the provisions: "*Lightning Clause*.—This policy shall cover any direct loss or damage caused by lightning, * * * meaning thereby the commonly accepted term lightning and in no case to include loss or damage by cyclone, tornado or wind-storm." "If a building or any part thereof fall, except as the result of fire, all insurance by this policy on such building or its contents shall

* Decision rendered, Sept. 22, 1916. 159 N. W. Rep. 416. Syllabus by the Court.

immediately cease." The insured frame building had been struck by lightning, and had begun to burn when all of the edifice above the floor of the first story was lifted by a tornado and deposited about 200 feet away, where it continued to burn until wholly destroyed. *Held*, that the fallen building clause did not apply, and that the insurer was liable.

(For other cases, see Insurance, Cent. Dig. § 1127; Dec. Dig. § 423.)

Appeals from District Court, Douglas County; Troup, Judge.

Actions by Martin Wiig against the Girard Fire & Marine Insurance Company of Philadelphia, Pa., and by the same plaintiff against the American Insurance Company of Newark, N. J. From judgments for plaintiff, defendants appeal. Affirmed.

Stout, Rose & Wells, of Omaha, for Appellants.

Byron G. Burbank, of Omaha, and E. R. Leigh, of South Omaha, for Appellee.



AMERICAN CENT. INS. CO. OF ST. LOUIS, Mo., *vs.*
SINCLAIR. (No. 6744.)*
(Supreme Court of Oklahoma.)

3. INSURANCE—ACTIONS ON POLICIES—EVIDENCE—SUFFICIENCY.

The record in this case examined, and *held*, there was sufficient evidence, if true, to warrant an inference that there had been a waiver of the iron-safe, books, and inventory clause in a fire insurance policy, and that the cause was properly submitted to the jury for their determination.

(For other cases, see Insurance, Cent. Dig. §§ 1711-1716; Dec. Dig. § 665[3].)

Error from District Court, McCurtain County; Summers Hardy, Judge.

Action by W. C. Sinclair against the American Central Insurance Company of St. Louis, Mo. Judgment for plaintiff, and defendant brings error. Affirmed.

Scothorn, Caldwell & McRill, of Oklahoma City, for Plaintiff in Error.
Steel, Lake & Head, of Idabel, and Ames, Chambers, Lowe & Richardson, of Oklahoma City, for Defendant in Error.

* Decision rendered, Sept. 26, 1916. 160 Pac. Rep. 60. Syllabus by the Court.



GREENBERG *vs.* GERMAN-AMERICAN INS. CO.*
(Supreme Court of Oregon.)

5. INSURANCE—CONTRACT TO INSURE—BREACH—PLEADING.

In an action for breach of an executory oral contract to insure property, the amended complaint, stating that plaintiff accepted the policy

* Decision rendered, Oct. 24, 1916. 160 Pac. Rep. 536.

issued by defendant through his ignorance of its legal effect, was insufficient to state a cause of action, since ignorance of the law will excuse no one.

(For other cases, see Insurance, Cent. Dig. §§ 192, 193; Dec. Dig. § 128[2].)

Department 2. Appeal from Circuit Court, Multnomah County; W. N. Gatens, Judge.

Action by William Greenberg against the German-American Insurance Company, a corporation. From a judgment for plaintiff, defendant appeals. Judgment reversed, and cause remanded.

John McCourt, of Portland (Veazie, McCourt & Veazie, of Portland, on the brief), for Appellant.

R. R. Giltner, of Portland (Giltner & Sewall, of Portland, on the brief), for Respondent.

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**WESTCHESTER FIRE INS. CO. vs. BOLLIN ET AL.
(No. 9527.)***

(Supreme Court of South Carolina.)

2. INSURANCE—LIABILITY OF AGENT—FAILURE TO CANCEL POLICY.

Where an insurance agent collected moneys for the company, it was not a condition precedent to the agent's liability for failure to cancel a policy that the premium be returned, or delivered to the agent in the absence of a showing that the agent had no funds of the plaintiff on hand.

(For other cases, see Insurance, Cent. Dig. § 108; Dec. Dig. § 83[2].)

3. INSURANCE—LIABILITY OF AGENT—FAILURE TO CANCEL POLICY—POWER OF SPECIAL AGENT.

It is no defense to an action for an insurance agent's failure to cancel a policy that the special agent who directed its cancellation had power to cancel it.

(For other cases, see Insurance, Cent. Dig. § 108; Dec. Dig. § 83[2].)

4. INSURANCE—LIABILITY OF AGENT—FAILURE TO CANCEL POLICY—CUSTOM OF OTHER AGENTS.

The conduct of other local agents when ordered to cancel policies is irrelevant in an action for an agent's failure to cancel, unless such conduct was brought to the company's knowledge.

(For other cases, see Insurance, Cent. Dig. § 108; Dec. Dig. § 83[2].)

5. INSURANCE—LIABILITY OF AGENT—ADMISSIBILITY OF EVIDENCE—INSTRUCTIONS TO AGENT.

In an action for an insurance agent's failure to cancel a policy, it was error to exclude evidence that the agent's attention was never called to the prohibited list.

(For other cases, see Insurance, Cent. Dig. § 108; Dec. Dig. § 83[2].)

* Decision rendered, Oct. 3, 1916. On petition for rehearing, Nov. 1, 1916. 90 S. E. Rep. 327.

7. INSURANCE—LIABILITY OF AGENTS—CONTRACT.

Where an insurance agent's contract required him to perform all lawful acts and business of such agency subject to the rules and regulations of the company, and such instructions as might be given from time to time by its officers or general agents, and there was evidence that the agent was directed to cancel the policy and undertook to do so, the verdict could not be directed for defendant in an action for failure to cancel the policy on the ground that plaintiff had not proved a contract requiring the agent to render that service.

(For other cases, see *Insurance, Cent. Dig.* § 108; *Dec. Dig.* § 83[2].)

8. INSURANCE—LIABILITY OF AGENTS—FAILURE TO CANCEL POLICY—DIRECTED VERDICT.

Where there was no evidence that an insurance agent knew the risk was prohibited, an action for failure to cancel the policy is based on negligence, and a verdict directed for plaintiff was improper, since negligence is a question for the jury.

(For other cases, see *Insurance, Cent. Dig.* § 108; *Dec. Dig.* § 83[2].)

Appeal from Common Pleas Circuit Court of Richland County; I. W. Bowman, Judge.

Action by the Westchester Fire Insurance Company against J. H. Bollin and A. W. Bollin, doing business under the firm name of J. H. Bollin & Sons. Judgment for the plaintiff on directed verdict, and defendants appeal. Reversed, and new trial ordered.

Frank G. Tompkins, of Columbia, for Appellants.
W. Anderson Clarkson, of Columbia, for Respondent.

ACCIDENT AND HEALTH.

SUPREME COURT OF NEW YORK.

APPELLATE TERM, SECOND DEPARTMENT.

ROSENFELD

v.s.

TRAVELERS' INS. CO., HARTFORD, CONN.*

1. INSURANCE—CONSTRUCTION AGAINST INSURER.

A policy issued by an insurance company, drawn in the language which it chooses, if ambiguous in any of its terms, is to be more strongly construed against the insurer than against the insured.

(For other cases, see Insurance, Cent. Dig. § 295; Dec. Dig. § 146[3].)

2. INSURANCE—ACCIDENT INSURANCE—RISK—PASSENGER.

Under a policy insuring against loss resulting from bodily injuries effected through accidental means, sustained while a passenger in or on a public conveyance, insured, who boarded a subway train, paid his fare and became a passenger, who alighted at a subway station between two tracks to change from a local to an express, and who, while attempting to get on a standing express train, was pushed by persons on the platform and persons leaving that train, and fell partly on the platform, with his feet hanging between the train and the platform, and who held a grab handle on the train, was, as a matter of law, a passenger "in or on" a public conveyance, within the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1164, 1173, 1174; Dec. Dig. § 452.)

Appeal from Municipal Court, Borough of Brooklyn, Fifth District.

Action by Harry Rosenfeld against the Travelers' Insurance Company, Hartford, Conn. From a judgment of the Municipal Court of the City of New York, Borough of Brooklyn, in favor of plaintiff, after a trial by the court without a jury, for \$204.75 damages and costs, defendant appeals. Affirmed.

Argued September term, 1916, before Benedict, Clark, and Jaycox, JJ.

Daniel Mungall, of Brooklyn, for Appellant.

Joseph Kleiner and J. M. Cohen, both of New York City, for Respondent.

BENEDICT, J.

This is an action for \$175 for seven weeks' indemnity at \$25 a week under a policy of insurance issued by defendant against loss from bodily injury arising from accidental causes. The answer denied knowledge or information sufficient to form a belief as to the fact of injury and its consequences.

[1, 2] The learned court below held, and as I think properly, that the plaintiff was entitled to a judgment against the defendant

* Decision rendered, September, 1916. 161 N. Y. Supp. 12.

for a sum which represented, according to the plaintiff's claim as amended at the trial, an indemnity at the rate of \$25 a week for and during the period of his total disability by reason of the accident of which he complains. There was presented to the trial court practically a single question of law, because the defendant did not, upon the trial, dispute that the plaintiff had sustained the injuries of which he complains, nor that, if he was entitled to recover anything, he was entitled to the sum which the trial court awarded to him. Whether the plaintiff was entitled to recover against the defendant under the terms of a policy of insurance against accident or casualty which it had issued to him, and which was admittedly in force at the time when the accident occurred, depended upon the construction to be given to the language used in the policy. By the terms of the policy, the defendant undertook to insure the plaintiff—"against loss resulting from bodily injuries effected directly and independently of all other causes through accidental means * * * sustained (a) while a passenger in or on a public conveyance provided by a common carrier for passenger service."

The plaintiff claims that he sustained the injury which caused his disability while he was a passenger within the meaning of the policy, and the defendant denies the legality of the claim.

The facts were these: Upon the 15th day of May, 1914, while the policy was in force, the plaintiff boarded a subway train at Twenty-eighth street on the Interborough subway on his way home from work and paid his fare for the trip, thereby becoming a passenger of a common carrier for passenger service. The train was proceeding in a southerly direction, and when it reached Fourteenth street he alighted from it onto the subway station between the two tracks, intending to change from the local train to an express train. He testified that he was pushed, while attempting to get on the express train, by persons on the platform and persons getting off the express train, and fell, half of his body going inside on the platform of the train and his feet hanging down between the train and the platform. He also testified that he held, with one of his hands, the grab handle of the train, and it was admitted that the express train was standing still at the time, having come to a full stop when he attempted to get on. There was sufficient evidence to justify the court in finding that the plaintiff, when the accident happened, had gotten, at least with some portion of his body, onto the express train, and that he was at least partly on the train and partly between the train and the station platform.

The defendant, upon the trial and on this appeal, has very strongly resisted the payment of the claim under its policy upon the ground that the plaintiff, when the accident occurred, was not "a passenger in or on a public conveyance provided by a common carrier for passenger service." The cases which it has

cited do not, in my judgment, support its contention, nor do I think that the terms of the policy ought to be given so narrow an interpretation as the defendant has sought to sustain. It is a well-settled rule of construction that a policy issued by an insurance company, and drawn in the language which the company itself chooses, is to be, if there be any ambiguity in the terms, more strongly construed against the insurer than against the insured. Especially is this true where, as in the present case, the indemnity is not a double indemnity, but a single indemnity.

If there remained any doubt in my mind that the court was justified in finding as it did that the plaintiff's injuries were sustained "while a passenger in or on a public conveyance provided by a common carrier for passenger service," the exception in a later part of the policy would go very far toward removing such doubt. The company was careful to provide that no liability should arise under the policy provided that the injuries were "sustained while entering or trying to enter or leave a moving conveyance." This exception has been held to be a valid exception in such a policy, and the fact that the company writing the policy inserted it as a safeguard to themselves against loss where the insured was attempting to enter or leave a moving conveyance indicates a recognition by the insurer that, were it not for the exception, it would be liable to the insured, and, if it were liable to the insured upon entering or leaving a moving conveyance, it surely would be liable to him upon his entering into or his departure from a conveyance which was not moving.

There is not only, as it seems to me, ample justification in reason for holding the defendant liable in this case upon the terms of its policy, but there is also ample authority in the adjudged cases for so doing. In 1 *Corpus Juris*, p. 440, § 93, it is stated:—

"Where the policy covers injuries received while a passenger, which extends to an injury received while getting on or off a conveyance such as the policy contemplates, or attempting to do so, as insured is a passenger under such circumstances."

In support of that proposition, the following cases are cited: *Tooley vs. Railway Pass. Assur. Co.*, 24 Fed. Cas. p. 53, No. 14,098; *Gibson vs. Casualty Co. of America*, 156 App. Div. 144, 140 N. Y. Supp. 1045; *Theobald vs. Railway Pass. Assur. Co.*, 10 Exch. 45.

Insurance against accidental injuries occurring while the insured is changing as a passenger in or upon a public conveyance protects him while attempting to board a moving train in the course of his journey. *Fidelity, etc., Co. of N. Y. vs. Morrison*, 129 Ill. App. 360. In the *Tooley Case*, supra, where the policy insured against injuries "received by the insured while actually traveling in a public conveyance provided by common carriers for the transportation of passengers," and the train stopped at a

station, and the insured left the train, which started up while he was off, and in attempting to get on again he was injured, it was held that, if the insured was traveling beyond the station, he could leave the train at the station and return to it again. He was not bound within the policy to remain thereon all the time, and he might recover for an injury received in attempting to get on or off.

In *Theobald vs. Railway Pass. Assur. Co.*, 10 Exch. (Hurl. & Gord.) 45, the plaintiff was insured against accidents happening "while traveling in any class carriage on any line of railway in Great Britain," and in attempting to alight from such conveyance after it had come to a stop slipped on the step and was injured. The court held that the insurance company was liable: Pollock, C. B., who delivered the opinion, saying:—

"It is quite plain that the plaintiff was a traveler on the railway; it is quite plain that, though at the time of the accident his journey had in one sense terminated, by the carriage having stopped, he had not ceased to be connected with the carriage, for he was still on it. The accident also happened without negligence on his part, and while doing an act which as a passenger he must necessarily have done, for a passenger must get into the carriage, and get out of it when the journey is at an end, and cannot be considered as disconnected with the carriage and railway, and with the machinery of motion, until the time he has, as it were, safely landed from the carriage and got upon the platform. The accident is attributable to his being a passenger on the railway, and it arises out of an act immediately connected with his being such passenger."

These cases and others which are cited in the notes in *Corpus Juris* sustain the conclusion reached in the court below, and that conclusion should be affirmed, with costs.

Jaycox and Clark, JJ., concur.



WORKINGMEN'S MUT. PROTECTIVE ASS'N *vs.* ROOS.

(No. 9117.)*

(Appellate Court of Indiana, Division No. 2.)

2. INSURANCE—ACCIDENT INSURANCE—TOTAL DISABILITY.

Where an accident policy indemnified against injury which shall wholly disable and prevent insured from performing every duty pertaining to any and every kind of business or occupation, and provided for payment for partial disability if his injuries shall prevent him from performing one or more important duties pertaining to his occupation, or

* Decision rendered, Oct. 13, 1916. 113 N. E. Rep. 760.

in the event of like disability immediately following total loss of time, the words "total loss of time," being read in connection with a stipulation with reference to total disability, make it clear that he would not be entitled to recover for total disability except in the event of total loss of time.

(For other cases, see Insurance, Cent. Dig. § 1310; Dec. Dig. § 524.)

Appeal from Circuit Court, Madison County; Charles K. Bagot, Judge.

Action by Leo Roos against the Workingmen's Mutual Protective Association. Judgment for plaintiff, and defendant appeals. Affirmed on condition that a remittitur is entered; otherwise, reversed with instructions to grant a new trial.

Teegarden & Kimble, of Anderson, and Long, Yarlott & Sonder, of Logansport, for Appellant.

Walter Vermillion, of Anderson, for Appellee.



HOLCOMB *vs.* GRAND LODGE, BROTHERHOOD OF
RAILROAD TRAINMEN.*

(Court of Appeals of Kentucky.)

INSURANCE—MUTUAL BENEFIT INSURANCE—POLICIES—
CONSTRUCTION—"TOTAL DISABILITY."

A policy issued by a fraternal insurer provided that the full amount of the benefits should be payable upon insured becoming permanently or totally disabled within the meaning of the constitution. The constitution declared that, should any member in good standing suffer amputation or severance of an entire hand or foot or the complete and permanent loss of both eyes, he should be considered totally and permanently disabled. Only railroad trainmen were eligible to join the order. Insured lost one eye by reason of a cinder, and the sight of the other eye was affected so that he could not continue his occupation of flagman, though he could see sufficiently to recognize people thirty or forty feet away. Held that, as the constitution was plain, and as there were no provisions that the term "total disability" should mean total disability from following railroad work, insured was not entitled to recover the benefit.

(For other cases, see Insurance, Cent. Dig. §§ 1961, 1962; Dec. Dig. § 791[2].)

(For other definitions, see Words and Phrases, First and Second Series, Total Disability.)

Appeal from Circuit Court, McCracken County.

Action by I. W. Holcomb against the Grand Lodge, Brotherhood of Railroad Trainmen. From a judgment for defendant, plaintiff appeals. Affirmed.

Campbell & Campbell and F. E. Graves, all of Paducah, for Appellant.
Wheeler & Hughes, of Paducah, for Appellee.

* Decision rendered, Nov. 1, 1916. 188 S. W. Rep. 885.

HAZEL vs. GOLDEN EAGLE ASS'N.*

(Supreme Court of New York, Appellate Term, Second Department.)

1. INSURANCE—LIABILITY OF INSURER—FAILURE TO PAY SICK BENEFIT.

Where a sick benefit was not paid by the insurer, until after the death of the insured, a judgment awarding the sick benefit to his estate in effect held that a refusal to pay one assessment was justified by failure to pay the benefit, the justification continued to the time of the death of the insured, and the decision applied to subsequent assessments after the date on which right to the sick benefit expired.

(For other cases, see Insurance, Cent. Dig. § 1906; Dec. Dig. § 754.)

4. INSURANCE—FAILURE TO PAY PREMIUMS—EFFECT OF TERMINATION OF POLICY.

Where an insurance company took the position that a policy was terminated by failure to pay one premium, the assured was not required to tender subsequent premiums, and the company was estopped from claiming that the assured was required to make such tender.

(For other cases, see Insurance, Cent. Dig. § 1906; Dec. Dig. § 754.)

5. INSURANCE—HEALTH INSURANCE—ACTION ON POLICY—COUNTERCLAIM.

In an action on a policy of health insurance by the administratrix of the insured to recover a sick benefit, the defendant had the right to interpose a counterclaim for any premiums it claimed were due and unpaid.

(For other cases, see Insurance, Cent. Dig. § 1991; Dec. Dig. § 809.)

Appeal from Municipal Court, Borough of Brooklyn, Sixth District. Action by Jennie Hazel against the Golden Eagle Association. From a judgment for defendant dismissing the complaint on the merits, plaintiff appeals. Reversed.

See, also, 159 N. Y. Supp. 1118.

Argued September term, 1916, before Clark, Jaycox, and Benedict, JJ.

Robert P. Lattimore, of New York City, for Appellant.

Hacker & Bowman, of New York City (William G. Decker, of New York City, of counsel), for Respondent.

* Decision rendered, September, 1916. 161 N. Y. Supp. 91.

HINES vs. NEW ENGLAND CASUALTY CO. (No. 256.)*

(Supreme Court of North Carolina.)

1. INSURANCE—HEALTH INSURANCE—STATEMENT IN APPLICATION—SOUNDNESS.

Statement in an application for health insurance, "I am in sound condition," is not matter vitiating the policy, notwithstanding insured had hernia, such variation from perfect condition not being asked about in the application, unless it was serious enough to affect his sound-

* Decision rendered, Oct. 11, 1916. 90 S. E. Rep. 131.

ness, so that one knowing the facts would say he was not sound; Revisal, § 4808, declaring all statements in an application to be merely representations, not preventing a recovery unless material.

(For other cases, see Insurance, Cent. Dig. §§ 687, 688; Dec. Dig. § 291[5].)

2. INSURANCE—SOUNDNESS—QUESTION FOR JURY—HERNIA.
Whether the hernia which insured had when in his application for health insurance he stated that he was in sound condition was of such nature as to render him unsound is a question of fact for the jury.

(For other cases, see Insurance, Cent. Dig. §§ 1737-1740, 1758-1760; Dec. Dig. § 668[7].)

3. INSURANCE—HEALTH INSURANCE—“CONFINED” IN HOUSE OR HOSPITAL.

Instructions in an action on a health policy providing for indemnity while insured is confined in his house or a hospital, *held* to properly state when one is “confined.”

(For other cases, see Insurance, Cent. Dig. § 1780; Dec. Dig. § 669[12].)

(For other definitions, see Words and Phrases, First and Second Series, *Confine.*)

Brown and Walker, JJ., dissenting.

Appeal from Superior Court, Franklin County; Connor, Judge.

Action by John D. Hines against the New Engand Casualty Company. Judgment for plaintiff, and defendant appeals. Affirmed.

Wm. H. Ruffin, of Louisburg, for Appellant.
W. H. Yarborough, Jr., and Ben T. Holden, both of Louisburg, for Appellee.

DUSTIN *vs.* INTERSTATE BUSINESS MEN'S ACC.

ASS'N. (No. 3954.)*

(Supreme Court of South Dakota.)

3. INSURANCE—HEALTH AND ACCIDENT—AVERAGE CLAUSE—CONSTRUCTION.

Clause in accident policy, limiting liability “if the member shall carry other accident insurance,” does not relate to time of application, but covers life of policy, and if, without notice to the insurer, the insured takes out another policy, the beneficiary can recover only the proportional value of the policy.

(For other cases, see Insurance, Cent. Dig. §§ 1309, 1316, 1317; Dec. Dig. § 530.)

5. INSURANCE—HEALTH AND ACCIDENT—AVERAGE CLAUSES—VALIDITY.

Clause in accident policy, limiting liability if insured carries other accident insurance, is not repugnant to clause requiring payment of stipulated sum on death, nor is it contrary to law, immoral, nor against public policy, but, if validly entered into, must be enforced.

(For other cases, see Insurance, Cent. Dig. §§ 1309, 1316, 1317; Dec. Dig. § 530.)

* Decision rendered, Oct. 4, 1916. 159 N. W. Rep. 395.

Appeal from Circuit Court, Lawrence County; James McNenny, Judge.

Action by Martha Alice Dustin against the Interstate Business Men's Accident Association. From judgment for plaintiff, and order overruling motion for new trial, defendant appeals. Reversed.

R. M. Haines, of Des Moines, Iowa, and J. M. Hodgson, of Deadwood, for Appellant.

Ogden & Ogden, of Deadwood, for Respondent.

CASUALTY, SURETY AND MISCELLANEOUS.**SUPREME COURT OF NEW YORK.
APPELLATE TERM, FIRST DEPARTMENT.**

LEVIN**v.s.****NEW ENGLAND CASUALTY CO.*****2. INSURANCE—LIABILITY INSURANCE.**

Where a policy against loss on account of bodily injuries accidentally suffered by the use of an automobile did not by its terms provide for consent by the insurer to a settlement of any claim for less than the \$5,000 limit of the policy, provided the sum the claimant was willing to accept was reasonable and fair and less than the amount that would probably be recovered in an action, and the insurer, to relieve itself of the payment of \$750 of the \$3,150 for which an injured party was willing to settle, refused to so settle unless the insured contributed \$750 to the amount, threatening to allow the case to go to trial and subject insured to the hazard of having a verdict recovered against him in excess of the \$5,000 limit of the policy, thus forcing insured to pay, insured had no cause of action to recover the \$750 so paid.

(For other cases, see Insurance, Dec. Dig. § 512.)

Appeal from City Court of New York, Special Term.

Action by William Levin against the New England Casualty Company. From an order overruling its demurrer to the amended complaint, defendant appeals. Order reversed, and demurrer, sustained, with leave to plaintiff to plead over.

Argued October term, 1916, before Guy, Bijur, and Shearn, JJ.

Menkel & Hinckley, of New York City (Wm. Cocks, Jr., and Anthony M. Menkel, both of New York City, of counsel), for Appellant.

Morris & Samuel Meyers, of New York City (George Wolf and Samuel Meyers, both of New York City, of counsel), for Respondent.

GUY, J.

In this action, based on a policy of accident insurance issued to plaintiff by defendant, plaintiff seeks to recover moneys which he claims defendant forced him to contribute toward the settlement of an action brought against him by one accidentally injured by plaintiff's automobile.

[1] Although the amended complaint alleges the making of the policy and performance of its conditions by the plaintiff, the policy is not made a part of the amended complaint, nor is its substance pleaded. The allegation that a copy of the policy is

* Decision rendered, Oct. 25, 1916. 160 N. Y. Supp. 1041.

attached to the original complaint does not make the policy a part of the amended complaint. As a result, therefore, many of the allegations as to the contents of the policy are mere conclusions of law.

[2] The complaint, however, sufficiently alleges the execution and delivery, on or about June 10, 1912, of a policy by defendant insuring plaintiff against loss or expense on account of bodily injuries accidentally suffered by reason of the use of his automobile, due performance of all the conditions of the policy on the part of the plaintiff, injuries accidentally sustained December 22, 1912, by one Feuer through the use of the automobile, and the bringing of an action against the plaintiff to recover \$10,000 damages for such injuries; that in full settlement of his claim Feuer subsequently consented to receive \$3,150, which sum was within the liability of \$5,000 assumed by the defendant under the policy, and represented a fair and reasonable settlement of the claim; that the defendant, for the purpose of relieving itself of the payment of part of said sum of \$3,150, namely, of \$750, and forcing and compelling the plaintiff to contribute the said sum to the defendant for the purpose of effecting a compromise and settlement of the action, unreasonably and unjustly refused to settle or compromise the claim unless the plaintiff would contribute \$750 to said sum of \$3,150, and threatened that, unless plaintiff would contribute said amount, defendant would allow the case to go to trial and subject the plaintiff to the hazard of having a verdict recovered against him in excess of the \$5,000 limit of the policy, and forced and compelled plaintiff to pay said sum of \$750. There is, however, no allegation that by the terms of the policy defendant agreed to consent to a settlement of any claim for less than the \$5,000 limit, provided the sum the claimant was willing to accept was reasonable and fair and less than the amount which would probably be recovered in an action. By paragraph XI of the complaint this is pleaded as a conclusion of law; but there is no agreement pleaded upon which such a conclusion of law could be predicated. The complaint fails to make out a cause of action.

The order overruling the demurrer must be reversed, with \$10 costs and disbursements, and the demurrer sustained, with \$10 costs, with leave to plaintiff to plead over within six days on payment of said costs. All concur.

**SUPREME COURT OF NEW YORK.
APPELLATE TERM, FIRST DEPARTMENT.**

DANERHIRSCH ET AL.

vs.

GREAT EASTERN CASUALTY CO.*

1. INSURANCE — ACTIONS — PLEADING — “EVIDENTIARY FACTS.”

In an action on a policy insuring against loss from burglary “provided there shall be visible marks of force and violence in forcing entry or exit,” insured must plead such marks, since facts essential to recovery are not “evidentiary facts,” but must be pleaded.

(For other cases, see Insurance, Cent. Dig. §§ 1599-1602; Dec. Dig. § 635.)
(For other definitions, see Words and Phrases, Second Series, Evidentiary Fact.)

Appeal from City Court of New York, Special Term.

Action by Joseph Danerhirsch and another against the Great Eastern Casualty Company. From an order denying motion for judgment on the pleadings, defendant appeals. Reversed, and motion granted.

Argued October term, 1916, before Guy, Bijur, and Shearn, JJ.

Joseph L. Prager, of New York City, for Appellant.

Strasbourger & Schallek, of New York City (Samuel Strasbourger and Max L. Schallek, both of New York City, of counsel), for Respondents.

SHEARN, J.

[1, 2] This action is brought to recover under a policy insuring against loss from burglary in plaintiff's premises “provided there shall be visible marks upon the premises of force and violence in forcing entry or exit.” The complaint alleges that the premises were broken into and “burglarized,” but fails to allege that there were any visible marks upon the premises of force and violence in forcing entry or exit, without proof of which there can be no recovery. Rosenthal vs. American Bonding Co., 207 N. Y. 162, 107 N. E. 716, 46 L. R. A. (N. S.) 561. Therefore the complaint, to which the contract of insurance is annexed, fails to disclose a cause of action. Facts which are absolutely essential to a recovery must be pleaded. They are not included in the classification of “evidentiary facts” merely because they have to be proved. “Evidentiary facts,” the pleading of which is dispensed with, are not those essential to the existence of a cause of action. It might as well be claimed that the allegation of a loss is evidentiary.

The order is reversed, with \$10 costs and disbursements, and

* Decision rendered, Oct. 17, 1916. 160 N. Y. Supp. 1015.

the motion granted, with \$10 costs, with leave to the plaintiff to amend the complaint within six days on payment of costs. All concur.

SUPREME COURT OF NEW YORK.
APPELLATE TERM, FIRST DEPARTMENT.

HAAS ET AL.

vs.

FIDELITY & DEPOSIT CO. OF MARYLAND.*

1. INSURANCE—BURGLARY INSURANCE—LOSS—PRESUMPTION AND BURDEN OF PROOF.

In an action on a policy insuring against burglary or theft, to recover the value of a diamond ring, etc., alleged to have been stolen from the insured's residence, evidence held to make out a *prima facie* case of a felonious abstraction of the ring, putting the insurer to its proof with respect thereto.

(For other cases, see *Insurance, Cent. Dig.* § 1722; *Dec. Dig.* § 665[4].)

Appeal from City Court of New York, Trial Term.

Action by David Haas and Sarah Haas, as executors of the estate of Leopold Haas, deceased, against the Fidelity & Deposit Company of Maryland. From a judgment of the City Court dismissing the complaint, plaintiffs appeal. Reversed, and new trial ordered.

Argued October term, 1916, before Guy, Bijur, and Shearn, JJ.

Prince & Nathan, of New York City (Leon M. Prince and Alfred B. Nathan, both of New York City, of counsel), for Appellants.
Arthur C. Mandel, of New York City, for Respondent.

GUY, J.

The action was brought by Leopold Haas upon defendant's policy insuring against burglary, larceny, and theft, to recover the sum of \$920, the alleged value of a diamond ring, diamond breast pin, and silk robe, claimed to have been stolen from the residence of the holder of the policy between November 16, 1912, and January 7, 1913. There have been three trials in this case. Before the first trial the plaintiff died, and the action was continued by his executors.

The testimony introduced by the plaintiffs at the last trial was that Leopold Haas, the owner of the diamond ring, lived at 19 West Ninety-sixth street; that he was seventy-three years old, had been ill for a long time prior to November 23, 1912,

* Decision rendered, Oct. 25, 1916. 160 N. Y. Supp. 1101.

suffering from hardening of the arteries; that he was very feeble, very sick, partially paralyzed, could not talk very much, and at the time of the alleged disappearance of the property in the care of a man nurse. On the date named his daughter, Rebecca Weiner, swore that he wore two rings—a large diamond ring, set in a gypsy setting, that came first (and which according to the testimony had been given him by his wife on the twenty-fifth anniversary of their wedding), and after the diamond ring a very small guard ring. The sick man's room was in the back of the extension on the first floor, separated from the bathroom by a hallway. On November 23d the nurse put Haas into a rolling chair and rolled him into the bathroom, and at the time he was thus taken into the bathroom he wore the diamond ring already described. The nurse closed the bathroom door and locked it, and they were the only persons in the bathroom. In about an hour and a half after they went into the bathroom Mrs. Weiner went into her father's room and saw him in bed; the nurse was not there; the daughter saw that her father did not have the rings on; and the nurse who did not come back into the room until about twenty-five minutes after the daughter went there on the second occasion, just came in when she missed them. She immediately went out into the bathroom and looked all over and could not find the rings; she then looked in the tub and found the guard ring, which was larger than the diamond ring, in the sieve; with others of the family she looked under the mat, in the hall, and all over in her father's room, but could not find the diamond ring. A plumber was then sent for, and in the presence of Mrs. Weiner and other members of the family he examined the bathtub and the strainer, tore up the tiled floor, located the trap, made an opening in the trap, so that he could see into it, and get his hand into it, and other members of the family put their hands into the trap, but there was nothing found there. He then, with one or more members of the family, went down-stairs to the main sewer in the cellar, opened the cover of the main trap, and put his hand down and brought out a lot of sediment, rust, pins, needles, and stuff gathered there, but could not find the ring. After November 23d the plumber examined the main trap two or three times, and found some little brass rings there. He tried to put a five-cent piece through the strainer of the bathtub, but it would not go through. The diamond ring was never found. The testimony of Mrs. Weiner and of the plumber was corroborated by other members of the household. At the close of the plaintiff's case the learned trial court dismissed the complaint, on the ground that the "proof of larceny is insufficient."

[1] Upon the record made by plaintiffs the defendant should have been put on its proof with respect to the diamond ring. The plaintiffs were not required to show by direct evidence a

felonious abstraction of the property; it was enough if they showed circumstances sufficient to raise an inference that the property was feloniously abstracted; and we are of opinion that the plaintiffs made out a *prima facie* case. *Stich vs. Fidelity & Deposit Co. of Maryland*, 159 N. Y. Supp. 712; *Orlando vs. Gt. Eastern Casualty Co.*, 91 Misc. Rep. 539, 155 N. Y. Supp. 20; *Fienglass vs. New Amsterdam Casualty Co.*, 151 N. Y. Supp. 371.

[2] That plaintiffs' witnesses had added to their testimony given on the former trials was a circumstance to be considered by the jury in arriving at their verdict; it did not as a matter of law render their testimony incredible.

[3] Respondent claims that the holder of the policy breached the warranty that he had never sustained a loss by burglary, theft, or larceny; but, as this defense was not pleaded, it cannot be considered on the appeal.

Judgment reversed, and a new trial ordered, with costs to the appellants to abide the event. All concur.



SUPREME COURT OF NEW YORK.

APPELLATE TERM, FIRST DEPARTMENT.

GOLDBERG

vs.

MASSACHUSETTS BONDING & INS. CO.*

INSURANCE—INSURANCE AGAINST THEFT—BREACH OF WARRANTY.

Where a policy insuring against theft contained in an annexed schedule warranty that assured had "no burglary insurance, and has made no application for such insurance," a clause in the policy itself, providing that "if assured carried other insurance the insurer should be liable only for its pro rata share of any loss," and assured had had a similar policy, which had been recalled by the insurer under its absolute right, there was no breach of warranty by insurer, as the warranty applied only to existing insurance, or any outstanding application for it.
(For other cases, see *Insurance*, Cent. Dig. §§ 660-669; Dec. Dig. § 288[1].)

Appeal from City Court of New York, Trial Term.

Action by David Goldberg against the Massachusetts Bonding & Insurance Company. From a judgment for defendant, plaintiff appeals. Judgment reversed, and new trial granted.

Argued October term, 1916, before Guy, Bijur, and Shearn, JJ.

* Decision rendered, Oct. 25, 1916. 160 N. Y. Supp. 1089.

Goldstein & Goldstein, of New York City (David Goldstein, of New York City, of counsel), for Appellant.
Joseph L. Prager, of New York City, for Respondent.

BIJUR, J.

The action was brought for a loss by theft covered by a policy of insurance issued by the defendant. The verdict was directed on the ground that it appeared affirmatively that plaintiff had breached a warranty contained in the policy.

The only question involved on this appeal is the interpretation of the warranty. This warranty is contained in a "schedule" annexed to the policy, which schedule is a series of questions with the answers of the insured. The warranty reads:—

"10. The assured has no burglary insurance, and has made no application for such insurance except as follows: None."

It developed on the trial that the assured had had a similar policy from another company, issued in March, 1913, which was recalled by the insurer (under its absolute right under the terms of the policy) on April 29, 1913. The policy in suit was issued June 14, 1913.

The error in respondent's contention consists in a failure to recognize the terms of the warranty.

In point 1 the respondent's counsel says:—

"It being undisputed that plaintiff had made a previous application for insurance, it was clear that there was a breach of warranty." And further: "If the warranty here merely read that the assured had no other prior insurance, there might be some merit to the appellant's claim; but the warranty also stated that the assured had made no application for such insurance."

The terms of the warranty, however, do not expressly nor impliedly relate to prior insurance.

It seems quite plain to me that the inquiry was directed to ascertain whether the assured had any other existing insurance or had any outstanding application for such. This meaning was emphasized by a clause in the policy itself which provides:—

"7. If the assured carry other insurance * * * the company shall be liable only for its pro rata share of any such loss."

In another connection, the respondent, in order to emphasize the claimed importance of this warranty, speaks of the "moral risk which the insurance companies have to consider and weigh." But it is plain that this inquiry is not directed to the moral risk, and respondent's counsel accentuates that consideration by citing *Wolowitch vs. National Ins. Co.*, 152 App. Div. 14, 136 N. Y. Supp. 793, in which, as he says:—

"The assured warranted that he had never been refused burglary insurance and had applied for none other than the policy in suit."

No inquiry like that indicated in the Wolowitch Case is contained in the warranty in the case at bar.

It does not require the application of the well-established principle (recognized in *Rosenthal vs. Am. Bonding Co.*, 207 N. Y. 162, 168, 169, 100 N. E. 716, 46 L. R. A. [N. S.] 561) that, the policy having been drawn by the defendant-respondent, its terms must be strictly construed as against it, to compel the inference that the terms of this warranty could not reasonably have been expected to suggest to the insured an inquiry as to prior insurance obtained by him which had either expired or been canceled or as to the applications therefor; and, indeed, its terms do not refer to such a contingency.

There having been, therefore, no breach of the warranty, as matter of law, the judgment must be reversed, and a new trial granted, with costs to appellant to abide the event. All concur.



NATIONAL LIVE STOCK INS. CO. *vs.* OWENS ET. AL.
(No. 9121.)*

(Appellate Court of Indiana, Division No. 1.)

4. INSURANCE—ACTIONS—PLEADING.

It being unnecessary in suit on policy to make the application a part of the complaint or to allege or prove that answers therein were true, the defense of false answers constituting warranty is not admissible under a general denial under Burns's Ann. St. 1914, § 361, which requires all defenses except the mere denial of facts alleged by plaintiff to be pleaded specially.

(For other cases, see Insurance, Cent. Dig. §§ 1617, 1618; Dec. Dig. § 640[2].)

5. INSURANCE—FALSE ANSWERS IN APPLICATION—VALIDITY OF POLICY.

Mere falsity of an answer in the application is insufficient to avoid the policy unless the insurer took steps to avoid it for such false warranty, by tendering to the insured the premium already paid.

(For other cases, see Insurance, Cent. Dig. § 549; Dec. Dig. § 256[1].)

8. INSURANCE—REPRESENTATIONS—EFFECT OF FALSITY.

A mere representation, as distinguished from a warranty, in an application for insurance on the life of an animal, although false, will not necessarily avoid the policy in the absence of bad faith, unless it is substantial and material to the risk; but, if statements are warranted to be true and the policy is issued upon the agreement that such statements are warranted, the warranty must be strictly satisfied.

(For other cases, see Insurance, Cent. Dig. §§ 549, 567; Dec. Dig. § 256[1], 267.)

* Decision rendered, Oct. 27, 1916. 113 N. E. Rep. 1024.

9. INSURANCE—WARRANTY—EFFECT OF FALSITY.

While a warranty relating to an existing fact must be literally true, or the policy does not attach, that which is promissory in its nature is not so strictly construed, and in the later cases it has been held sufficient if substantially true or performed.

(For other cases, see Insurance, Cent. Dig. § 698; Dec. Dig. § 304.)

10. INSURANCE—CONSTRUCTION OF POLICY—WARRANTIES.

Insurance contracts are to be strictly construed against the company if necessary to prevent forfeiture of the policy, and a warranty is created only by the most unequivocal language, and where words used permit two interpretations, that most favorable to the insured will be adopted.

(For other cases, see Insurance, Cent. Dig. § 564; Dec. Dig. § 264[2].)

12. INSURANCE—INSURANCE OF ANIMALS—APPLICATION—WARRANTIES.

Answers to questions, in an application for insurance on a horse, that the insured had not lost live stock by death, accident, disease, or theft within two years, and that the horse insured would be cared for by the insured, expressly made warranties by the terms of the application, must be construed as warranties.

(For other cases, see Insurance, Cent. Dig. § 564; Dec. Dig. § 264[2].)

Appeal from Circuit Court, Johnson County; Wm. E. Deupree, Judge.

Action by Walter Owens and another against the National Live Stock Insurance Company. Judgment for plaintiffs, and order overruling motion for new trial, and defendant appeals. Reversed, with instructions.

M. S. Meyberg and L. Ert Slack, both of Indianapolis, for Appellant.

Elba L. Branigin and Thomas Williams, both of Franklin, for Appellees.



CURTIS & GARTSIDE CO. vs. AETNA LIFE INS. CO.

(No. 5982.)*

(Supreme Court of Oklahoma.)

1. INSURANCE—EMPLOYERS' LIABILITY INSURANCE—NATURE OF CONTRACT.

A clause in a policy undertaking to indemnify assured against loss by reason of liability on account of injuries to employees, by which the insurer undertakes to defend proceedings against the assured, unless it should elect to settle the same or pay the assured the indemnity provided for, does not make the contract one guaranteeing payment of an obligation of the assured, rather than one of indemnity, where another clause of the policy provides that no action shall be brought against the insurer unless by the assured himself to reimburse him

* Decision rendered Oct. 10, 1916. 160 Pac. Rep. 465. Syllabus by the Court.

for loss actually sustained and paid; the former clause being merely an additional privilege for the protection of the insurer.

(For other cases, see Insurance, Cent. Dig. § 1298; Dec. Dig. § 514.)

3. INSURANCE—EXTENT OF LIABILITY—INTEREST.

Under a policy indemnifying an employer against loss, not exceeding \$5,000, by reason of liability incurred from injuries to employees, the insurer is not liable for interest on a judgment for \$5,000 pending an appeal taken by the insurer, who, by the terms of the policy, conducts the litigation.

(For other cases, see Insurance, Cent. Dig. § 1494; Dec. Dig. § 598.)

4. INSURANCE—EXTENT OF LIABILITY—INTEREST.

The extent of the company's liability under such policy is governed by the terms of the contract, and is thereby limited to \$5,000, and the expense of defending the action against the assured, if the company elects to defend, and the interest accruing on the judgment recovered in such action, pending an appeal therefrom, is not a part of such expense.

(For other cases, see Insurance, Cent. Dig. § 1494; Dec. Dig. § 598.)

Error from District Court, Oklahoma County; George W. Clark, Judge.

Action by the Curtis & Gartside Company against the Aetna Life Insurance Company. Judgment for defendant, and plaintiff brings error. Affirmed.

Ames, Chambers, Lowe & Richardson, of Oklahoma City, for Plaintiff in Error.

Everest & Campbell, of Oklahoma City, for Defendant in Error.



KUTSCHENREUTER *vs.* PROVIDENCE-WASHINGTON INS. CO. (No. 22.)*

(Supreme Court of Wisconsin.)

1. INSURANCE—SWORN STATEMENT OF LOSS—DENIAL OF LIABILITY.

Where an insurance policy requires, as a condition precedent to payment of loss, that the insured furnish a sworn statement thereof, he need not do so if the insurer absolutely denies liability.

(For other cases, see Insurance, Cent. Dig. §§ 1391, 1392; Dec. Dig. § 559[1].)

2. INSURANCE—SWORN STATEMENT OF LOSS—EXCUSE FROM FURNISHING.

Where an insurance policy requires that insured, as a condition precedent to payment of loss furnish a sworn statement thereof, an additional clause, making the agreement void if the statement is not furnished, adds nothing substantial to the policy, so far as the furnishing of the

* Decision rendered, Oct. 3, 1916. 159 N. W. Rep. 552.

statement is concerned, and, despite such additional clause, an absolute denial of liability by the insurer will excuse the insured's failure to furnish the sworn statement.

(For other cases, see Insurance, Cent. Dig. §§ 1391, 1392; Dec. Dig. § 559[1].)

Appeal from Circuit Court, Milwaukee County; F. C. Eschweiler, Judge.

Action by Herman Kutscheneruter against the Providence-Washington Insurance Company. From an order overruling demurrer to the complaint, defendant appeals. Order affirmed.

PRUDENTIAL LIFE INS. CO. OF TEXAS vs. PEARSON.

(No. 1018.)*

(Court of Civil Appeals of Texas. Amarillo.)

3. INSURANCE — STOCK — CONSIDERATION — PARTIAL ILLLEGALITY.

Although Rev. Stat. art. 4711, provides that the capital stock of insurance companies may consist of valid first mortgages on realty, an insurance company cannot, in view of Const. art 12, § 6, issue stock for note and trust deed, though it could invest in such security after the stock was paid.

(For other cases, see Insurance, Cent. Dig. § 88; Dec. Dig. § 33.)

Error from District Court, Hale County; R. C. Joiner, Judge.

Suit by H. S. Pearson against the Prudential Life Insurance Company of Texas. Decree for plaintiff, and defendant brings error. Affirmed.

Jas. A. King, of Floresville, and Mathes & Williams, of Plainview, for Plaintiff in Error.

Madden, Trulove, Ryburn & Pipkin, of Amarillo, and C. D. Russell and L. R. Pearson, both of Plainview, for Defendant in Error.

* Decision rendered, June 28, 1916. Rehearing denied, Oct. 4, 1916. 188 S. W. Rep. 513.

EBERLEIN vs. FIDELITY & DEPOSIT CO. OF MARYLAND.*

(Supreme Court of Wisconsin.)

2. INSURANCE—INDEMNITY INSURANCE — CONDITION PRECEDENT TO RIGHT OF ACTION.

Policy of insurance, indemnifying employer against loss through injuries to employees, is contract to indemnify assured alone, and payment of

* Decision rendered, Oct. 3, 1916. 159 N. W. Rep. 553.

loss by him is a condition precedent to his right to maintain an action on the policy.

(For other cases, see *Insurance, Cent. Dig. § 1298; Dec. Dig. § 514.*)

3. INSURANCE—INDEMNITY INSURANCE—LACK OF PAYMENT BY ASSURED.

Where a corporation insured against loss sustained through injuries to its employees, the policy providing that it must pay the injured employee before having a right of action against the insurer, gave an absolute note to a bank, which the injured employee's attorney indorsed, executing a satisfaction of judgment and depositing in bank the money given by the bank on the note, taking an assignment of the corporation's right of action, the attorney could not recover on the policy, since the corporation had made no payment on the injured employee's judgment.

(For other cases, see *Insurance, Cent. Dig. § 1298; Dec. Dig. § 514.*)

Appeal from Circuit Court, Forest County; Wm. B. Quinlan, Judge.

Action by M. G. Eberlein against the Fidelity & Deposit Company of Maryland. From a judgment for plaintiff, defendant appeals. Judgment reversed, and action remanded, with directions to render judgment for defendant, dismissing the complaint.

Williams & Stern, of Milwaukee, for Appellant.

Eberlein, Eberlein & Larson, of Shawano, for Respondent.

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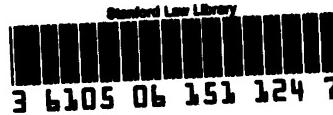
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